The Modern Hospital

SEPTEMBER 1958

Modern Hospital of the Month: William Beaumont Hospital, Royal Oak, Mich.

world's most advanced hospital furniture

WOODRIDGE... by Royal®

Designed to make patient rooms cheerful, restful, relaxing . . . WOODRIDGE, by *Royal* combines the warmth of wood with sturdy steel inner construction for beauty, efficiency and durability. Attractive Finnish Birch or American Walnut plywood panels and virtually indestructible Royaloid tops are individually replaceable for simplified maintenance. Drawers have nylon runners and glides, all-metal interiors . . . never warp or stick. Responsive *Royal* Hi-Lo Bed raises from 18″ to 27″ in seconds. Elevates at either end or both. Trendelenburg position in 10 seconds, Fowler position in 25 seconds.

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Glucose Concentration	Accuracy
2 percent	98.6 percent
0.5 percent	88.9 percent
0.25 percent	90.3 percent
0.1 percent	95.6 percent
0 percent	100 percent

A total of 5,500 different specimens were assayed, with an over-all accuracy of 98.6 percent.

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The Modern Hospital

SEPTEMBER 1958 VOLUME 91, NO. 3

Articles in this issue

Continued on next page ▸

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ROVING REPORTER

Babies Are Televised for Fathers' Benefit

Photographs by Flip Schulke, Black Star Publishing Company, Inc.

Top picture: Father watches his newborn child moments after her birth. Left: Television set is center of attention in fathers' waiting room. Right: Nurse Nelly Garms hold baby up to camera, which is above the examination table.

And Now We Present . . .

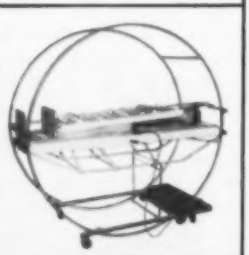
A television set is the center of interest in the fathers' waiting room at many hospitals. But at Hialeah Hospital, Hialeah, Fla., the men watch more intently than their colleagues elsewhere—for among the programs are their newborn children.

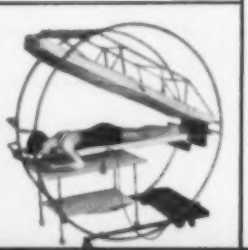
When the hospital built a new maternity department last winter, it installed a closed circuit television system, which included a video camera in the examining room adjacent to the nursery, and a standard television set in the fathers' room. The set is connected to the camera and controls by a small coaxial cable.

As soon as a baby is delivered, he is brought to the examining room for necessary care. Then the baby is placed under the camera, a switch is turned on, and the father is notified over the intercommunication system to change to Channel 6 on the television set. He turns the knob—and there's his baby.

The new routine is no extra work for nurses; all they must do is turn one switch and allow the tube to warm up for a minute or two. Since the tele-

A totally new concept in patient handling





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The new Circ O lectric Universal Hospital Bed is the first economical all-purpose unit developed for the comfort of the patient and for the convenience of the nurse.

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For additional information write, or call today.

Stryker Manufacturing Quality Medical Equipment for 15 years

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vision camera is focused on the examination table where the baby is measured and weighed, the nurse can give the father these details over the intercommunication system at the same time he is seeing his new baby.

The fathers, the hospital has found, very much enjoy seeing their babies immediately over television. It also keeps them from crowding the nursery windows at times when fathers and visitors are not allowed in the maternity department.

Another advantage of the system: Young brothers and sisters of the new baby can get a glimpse of him. Of course, they are not permitted in the maternity department, but they can be allowed to see the baby on the TV.

In fact, this was the situation that brought about the television system, reported Administrator Donald W. Welch. Mr. Welch himself had a new baby in the nursery, and his three-year-old daughter was anxious to see the infant. Since she could not go to the nursery, Mr. Welch began to think about some way to show the babies to children, and closed circuit television was the eventual result.

Cost of the installation is between $1500 and $2000, according to Mr. Welch, depending on how expensive a television set is purchased. The closed circuit equipment can, of course, be extended for use in other areas, such as surgery. The system has been an excellent public relations device for the hospital, and has made the maternity department the "talk of the town," Mr. Welch commented.

Syracuse Mails Its Story

Within the boundaries of Syracuse, N.Y., are 12 member hospitals of our hospital council, serving a population area of 600,000 persons. Six are community hospitals admitting 50,000 patients each year. The city is an important medical and hospital center.

However, during the past few years, patient comment and the general tenor of newspaper and radio editorializing made it obvious that, other than in a hazy, general way, there was little or no understanding of the role of the hospital within the area of Onondaga County.

Hospital problems were considered simply problems of the institution—not of the community.

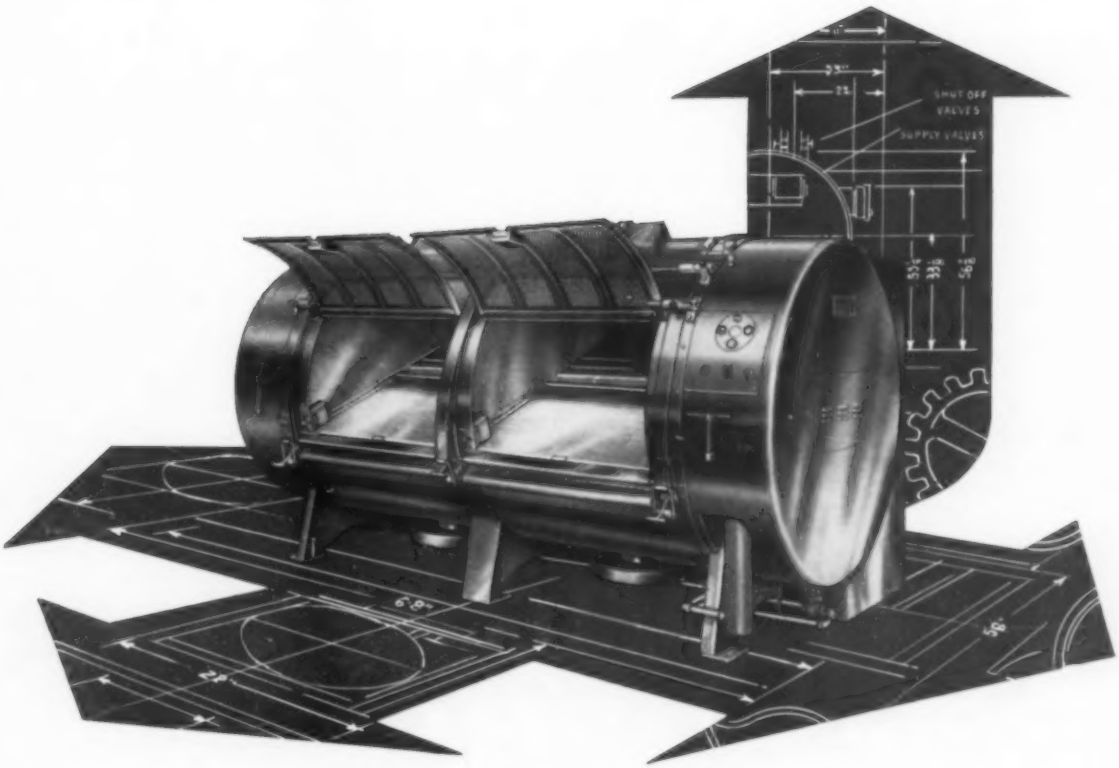
Several situations brought out this lack of knowledge: (1) the need to raise charges to meet costs; (2) the growing shortages of personnel interested in hospital careers; (3) the increasing difficulty of obtaining contributions for new equipment and research.

Also untold were the important stories as to what accreditation is, and what volunteer effort means to the hospital and the community; even the costs of operating the hospital were unknown to people in the community at large.

The result was as you might expect. People who should have known better were constantly comparing hospital room charges to costs for similar accommodations in hotels. The work of 8000 volunteers, ranging from the board members of the six voluntary hospitals to the strong auxiliary memberships, were largely ignored by the general public.

As part of a new public relations effort, the Syracuse Hospital Council developed and distributed a special series of eight mailings, designed to tell to a wide audience the story of its hospitals.

The subject matter included several



The hidden dimensions

IN LAUNDRY MACHINERY

Beyond the blueprints and floor plans, behind the specifications and cost figures, there are other important dimensions to be considered in the purchase of laundry machinery. These are in large part measures not of the machine, but of its manufacturer.

Troy, as the nation's oldest manufacturer of power laundry machinery, is proud of the way it has measured up in integrity and service during its 90-year history. The company holds an enviable reputation for truly objective surveys and equipment recommendations. In addition, Troy's nationwide sales and service representation with adequate stocks of genuine repair parts assures buyers of continuing satisfaction with the performance of Troy equipment. The company's program of pioneering research and development of new equipment is unsurpassed in the industry.

These are a few of the reasons why buyers can continue to look with confidence to Troy's complete line of quality laundry machinery.

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For additional information, use postcard on page 279.

topics, which we titled in the following ways:

"What the Hospital Is"

"Accreditation . . . What It Means to You"

"$11,000,000-Plus a Year" (The actual costs of operating the area's six voluntary hospitals each year, developed by survey.)

"The Hospital Council . . . What It Is"

"Your Hospital . . . A Training Center"

"The Hospital Is People"

"Focal Point for Volunteer Effort"

"On Science's Frontier"

Each item was reduced to its briefest format. Art work was prepared to portray both symbolically and realistically the hospital within the community.

Cost was kept to a minimum by printing each mailing on a multilith machine. Each folder was on a different colored stock.

Distribution was carried out in several ways:

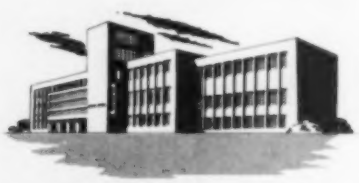
1. Special mailings were sent to all members of the press, radio and television, all hospital board members, all doctors, lawyers and a select list of 600 community leaders.

2. Enough copies were prepared for distribution to each of the area's 3000 hospital employes to provide them with a closer picture of their hospital in relationship to the community and to other hospitals in the area.

3. Copies were prepared for every hospital patient.

In order to reach an even greater audience, the material is being printed as a special 12 page brochure. This will be distributed in waiting rooms, to radio and television audiences, to all hospital auxiliary members, and during Hospital Week at display locations.

Where possible, the material is being mailed to the individual's home so that a greater audience can be reached.



What Is A Hospital?

SYRACUSE HOSPITAL COUNCIL

One of the eight mailing pieces prepared and distributed to some 2500 community leaders in Syracuse, N.Y. Material will be produced in booklet form for hospital employes, patients, volunteers, and the general public.

The early effectiveness of the mailing is indicated in the response of several newspaper columnists. Radio and television programs are being based on the material, and a series of eight articles, an abridgement of the series, is being prepared for the area's 15 weekly newspapers.

The mailings are the first step in our long-range program to fill a serious void in the community hospital story.—JAMES H. ABBOTT, *president, Syracuse Hospital Council,* and *administrator, University Hospital of the Good Shepherd, Syracuse, N.Y.*

Destroys "Golden Villain" ...and makes Hospital Budgets go further!

LAB "ONE"

AUTOMATED DISINFECTANT CONDITIONER CLEANER!

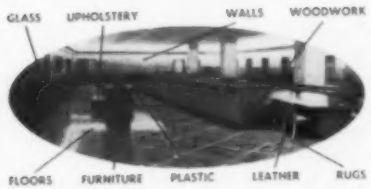
ONE MAN-HOUR EQUALS TWO ® AUTOMATED MAINTENANCE ONE OPERATION INSTEAD OF MANY

...has exclusive

ACTINITE

SUPER CLEANING POWER!

LAB "ONE" with Actinite super-cleaning power gives you the ultimate in sanitary hospital maintenance: an automated *chemical work force* all-in-one product!



ALL PURPOSE . . . ALL SURFACES! Lab "One" is built to work at top efficiency on every surface. One product, one operation does everything.

What is an AUTOMATED PRODUCT?

It is a product, built on a new concept, which replaces hard manual labor with an automatic chemical work force. Each Automated product performs many operations at one material-and-labor cost—and provides *automated maintenance.*

THE PROBLEM

In the face of dramatically increased labor costs, today's modern hospital must meet the terrifying problem of Staphylococcus Aureus *at the same time* it's trying to hold down its maintenance budget! Direct labor consumes over 90c of the hospital's maintenance dollar. Is it possible to wage war against the Golden Villain . . . and *decrease* maintenance labor costs *while you do it?*

THE SOLUTION

LAB "ONE", the automated disinfectant conditioner cleaner with exclusive Actinite super-cleaning action, will remove *housekeeping* as a source of infectious contamination . . . *and* will cut labor costs up to 80%! In one easy application, LAB "ONE" kills staph aureus and a wide range of other dreaded disease bacteria . . . at the same time, it cleans, renovates, deodorizes and brightens colors on all surfaces: floors, walls, ceilings, tables, upholstery, ducts, washrooms, etc. With LAB "ONE", your maintenance personnel can make one man-hour equal two or more, and do up to five jobs with one easy application!

THE REASON

LAB "ONE" is a combination of seven separate chemical cleaning compounds fused into a single concentrated liquid. "Actinite" super-cleaning action extends the detergency range of LAB "ONE's" multi-performance, giving you a *chemical work force* that makes light of difficult tasks. It relieves maintenance labor budgets, and costs but a trifle in the bucket! Can be used in dilutions as high as one part per 120 to 140 parts water. *LAB "ONE" has a guaranteed minimum coefficiency of 7 against Staphylococcus Aureus. Prove it yourself!* Test famous LAB "ONE" on any surface.

Write for sample, literature and distributor's name today.

LAB AUTOMATED CHEMICALS

Howard & West Streets ★ Baltimore 30, Maryland

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The Hospital Administrator Needs To Have a Two-Sided Personality

By Gordon Davis

Gordon Davis

I'LL admit it's slightly fantastic, but wouldn't the pace of human progress accelerate spectacularly if each of our organizations and institutions could be headed by two persons rather than one?

The function of one of these individuals would be to serve as promoter, publicist and spokesman. The other would be the administrator and executive who saw to it that the work got done.

This is indeed a fantasy, for two people cannot both be boss, and a boss there invariably must be. Still, the combination of expert promoter and able executive is rarely found in one person, and both qualities are important to institutional advancement.

Both qualities also are important to public relations. This is implicit in the formula which asserts that good public relations is the result of good performance plus adequate interpretation. The performance is the concern of the executive or administrative type; the interpretation the joy of the gregarious soul who communicates fully with his fellows.

If you consider the executives whom you know personally, you will find that virtually all of them tend toward one type or the other.

There are executives who are splendid administrators but have a tough time building support for their projects because they lack natural ability to communicate, and there are those who communicate at the drop of an adjective but can't seem to master the technics of administration.

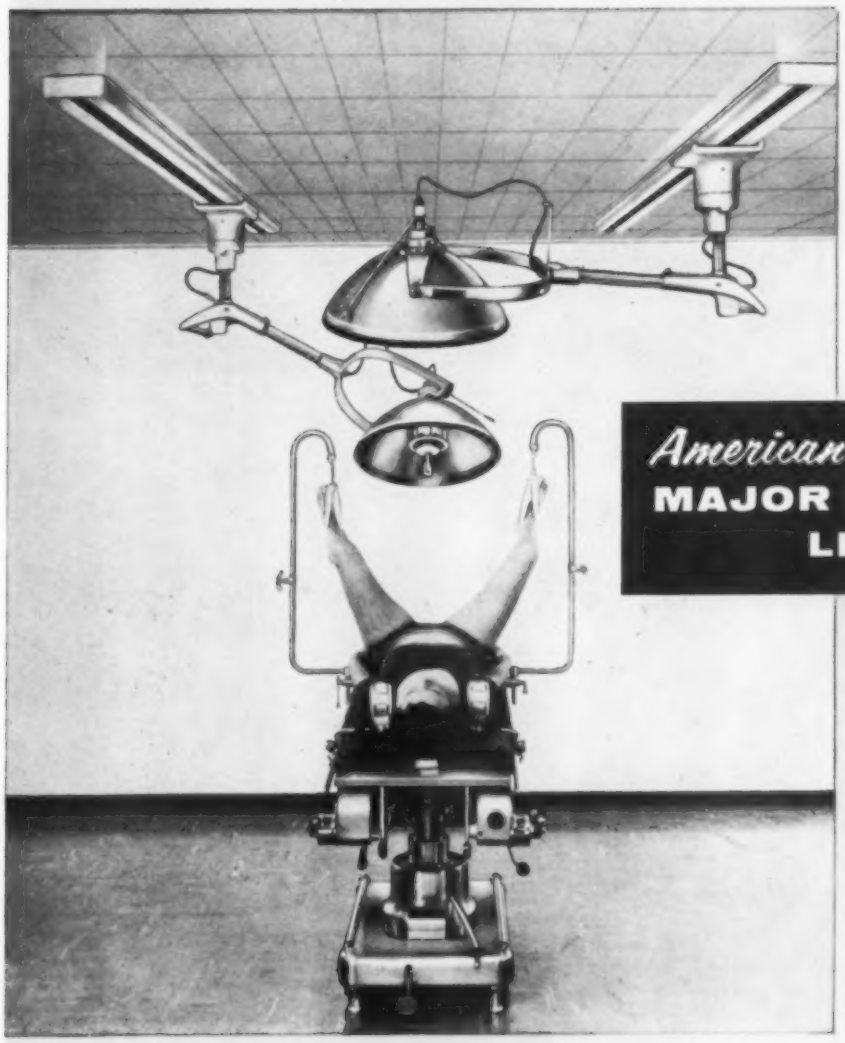
Unfortunately, basic responsibility for both jobs must remain with the chief executive of any organization. It is not possible to buy good public relations by hiring others to take care of communications while the administrator erases that worry from his mind. All that can be bought is specialized help to make the communications job easier.

The institution of an organized public relations program, in other words, defeats its own purpose if it further insulates the administrator from contacts with patients, public and the press. It should have exactly the opposite effect. It should strip away some of the insulation, produce increased capacity for public contacts, lead to better understanding of public attitudes on the administrator's part.

In the public relations sense, if not in the administrative sense, the best hospital executive probably will always be the one who finds time to talk to people — to make the rounds of patients, to appear before community groups, to visit with newspaper editors and reporters, to share his thinking liberally through personal contacts with employes, medical staff, auxiliary and many other groups.

Organized public relations helps to systematize such contacts, to give them specific and rewarding purpose and continuity. For the naturally articulate administrator, it multiplies his effectiveness. For the administrator who is less vocal, it brings new means of developing better understanding of his problems and objectives.

But the basic responsibility is always the administrator's. That is part of the price of leadership. ■



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NEW
Remote Control Pantograph Arm.

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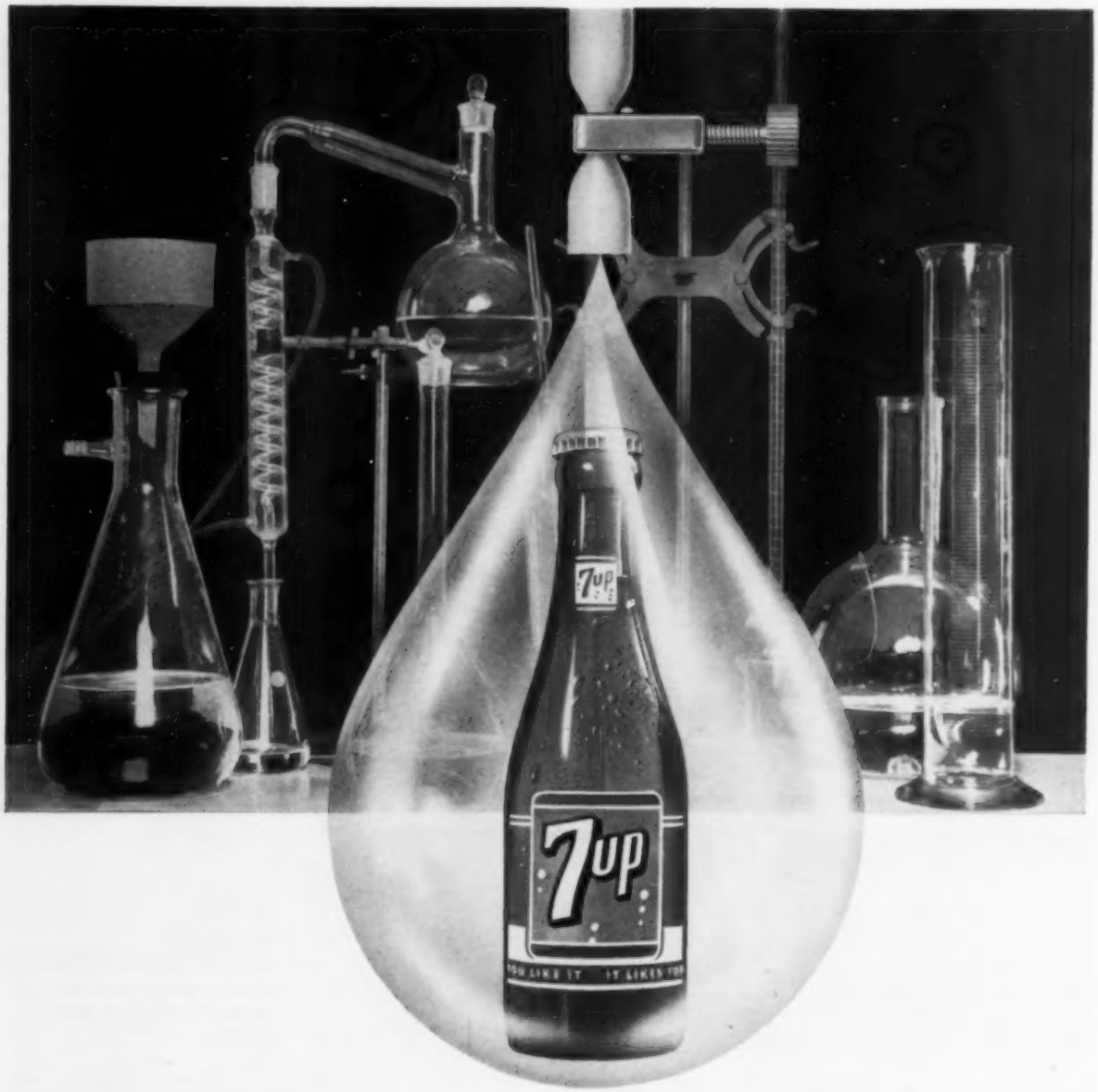

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We start with drinking water approved by the U.S. Public Health Service. But 7-Up goes several steps beyond their critical standards.

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Water so purified is odorless, colorless and tasteless. There's nothing in it to alter the true flavor of 7-Up.

That's why 7-Up tastes exactly the same every place—fresh, clean—no matter where you uncap the familiar green bottle.

Nothing does it like Seven-Up!

Result: New products that offer new economies

These recent Lily developments help you speed up service—with less effort, at less cost.

The Man With The Lily Plan is tackling a problem—so he can help drop your costs to a minimum. Such unrelenting efforts have provided volume feeders with a cost-conscious team of new products, plus important improvements on proven products.

For example, Lily* place settings (shown in kit) offer all kinds of economies—from soup to nuts. They're completely disposable, thus eliminating labor costs involved in scraping, washing, drying and storing. They also eliminate need for dishwashers, expense of maintaining them, and additional cost of hot water, soap and detergents.

Simplify service, lighten trays

Lily place settings provide a matched service for nearly every food and beverage on your master menu. They require less storage space, eliminate the expensive problem of breakage, cut time and effort involved in bussing. Lily paper service also simplifies serving and after-service.

Volume feeders of all kinds use Lily place settings to save valuable time, and to reduce fatigue caused by carrying heavy, dish-laden trays.

New Lily exclusive

Lily offers three sizes of molded smooth plates: 6, 9, and 10 in., plus two sizes of compartmented molded plates, 9¼ and 10¼ in. The 9¼ in. plate, made by Lily alone, has that extra rigidity needed for confident one-hand handling. Its "full depth" compartments control portions and costs better, keep foods and companion juices and gravies in place. 10¼ in. plate has same features but allows for larger portions.

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Lily is constantly striving — through research, through product development, through product improvement — to find new economy measures, new convenience features. We'd be happy to show you how specific findings apply to your operation. We'd also be happy to send you free samples of the products above. Just write: *Lily-Tulip Cup Corporation, Dept. MH9, 122 East 42nd Street, New York 17, New York.* *T.M. Reg. U.S. Pat Off.

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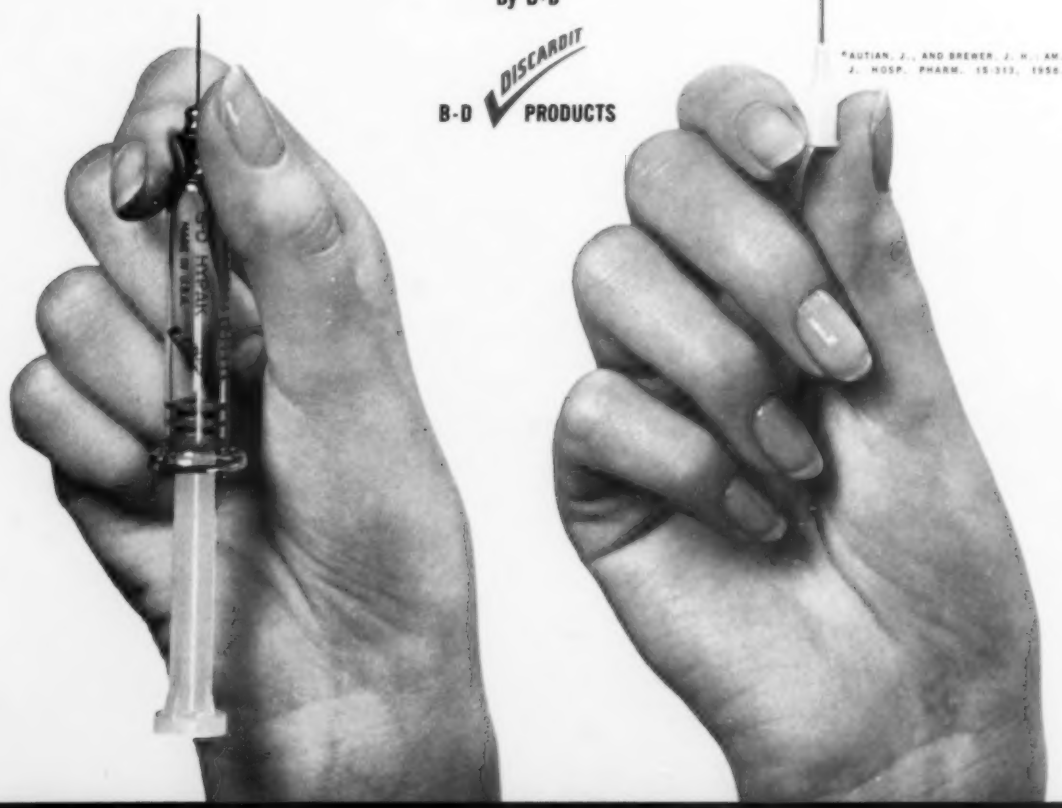
*LAUTIAN, J., AND BREWER, J. H., AM. J. HOSP. PHARM., 15:313, 1958.



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EASILY AND QUICKLY ASSEMBLED—no tedious matching of parts.
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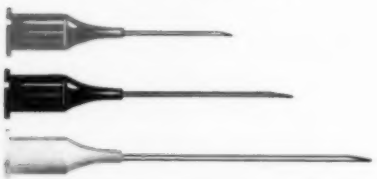
YALE
Sterile Disposable Needle



HYPAK Sterile Disposable GLASS
Syringe-Needle Combination

PACKAGED for hospital convenience

YALE STERILE DISPOSABLE NEEDLES—for all B-D Luer-Lok and Luer-Slip Syringes

Catalog No.	Gauge	Color Code
HSYN	25 Gauge x 5/8"	(Blue)
HSYN	22 Gauge x 1"	(Black)
HSYN	22 Gauge x 1½"	(Black)
HSYN	20 Gauge x 1"	(Yellow)
HSYN	20 Gauge x 1½"	(Yellow)

100 needles (20 strips of 5) in sturdy package with handy slide-off sleeve for disposing of used needles. Shelf package: 1000 needles. Case: 5 shelf packages (5000 needles)

HYPAK STERILE DISPOSABLE GLASS SYRINGE-NEEDLE COMBINATION

A702	2 cc. with 25 x 5/8" needle	(Blue)
A702	2 cc. with 22 x 1" needle	(Black)
A702	2 cc. with 22 x 1½" needle	(Black)
A702	2 cc. with 20 x 1½" needle	(Yellow)

Individual unit in sealed polyethylene bag. 20 units per box. Shelf package: 25 boxes (500 units). Case: 2 shelf packages (1000 units).

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DR. L. G. CRANWELL, owner of the Bledsoe Memorial Hospital.

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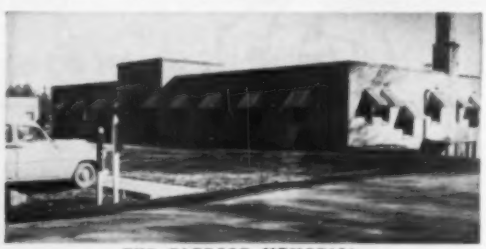
A NATIONAL SYSTEM handles all record-keeping work quickly and efficiently.



THE BLEDSOE MEMORIAL HOSPITAL in Pikeville, Tenn.

"Our *National* System saves us $2,900 a year... pays for itself every 11 months."—Bledsoe Memorial Hospital, *Pikeville, Tenn.*

"Our new National System gives us complete control over all money handled by the Clinic," writes Dr. L. G. Cranwell, owner of the Bledsoe Memorial Hospital. "As a result, it provides greater protection for our patients and our staff.

"Since all information is posted with maximum speed and efficiency by our Nationals, our records are always posted to date. This means that statements are always ready on time and that important information is immediately available to us.

"Through increased operating efficiency, our National System saves us at least $2,900 a year, pays for itself every 11 months."

L. G. Cranwell

owner of the Bledsoe Memorial Hospital

Your hospital, too, can benefit from the time- and money-savings features of a National System. Nationals pay for themselves quickly through savings, then continue to return a regular yearly profit. National's world-wide service organization will protect this profit. Ask us about the National Maintenance Plan. (See the yellow pages of your phone book.)

*TRADE MARK REG. U. S. PAT. OFF.

National

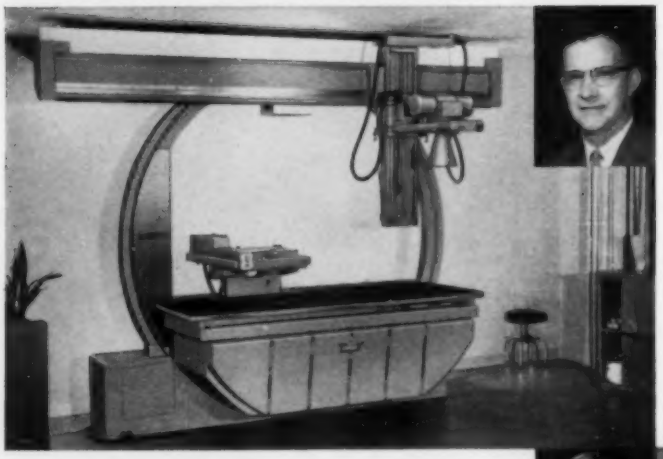
CASH REGISTERS • ADDING MACHINES
ACCOUNTING MACHINES
NCR PAPER (NO CARBON REQUIRED)

THE NATIONAL CASH REGISTER COMPANY, Dayton 9, Ohio

1039 OFFICES IN 121 COUNTRIES • HELPING BUSINESS SAVE MONEY

General Electric's x-ray representatives are trained consultants whose sense of responsibility to you goes far beyond sales alone. Here, four of these men report on the G-E diagnostic line to help you...

Choose your



THE IMPERIAL

"It's a pleasure to work with the radiologist who's ready to own an Imperial," reports W. M. Ross, Atlanta, Ga. "You sort of share a milestone with him . . . know you're outfitting him with our *finest* diagnostic unit. My customers are most impressed by Imperial's deluxe automatic spot-film device and phototimer and unusual 180° ring-rotated table. These and other features seem to fulfill the radiologist's desire for equipment that behaves like an extension of himself. And the Imperial makes it possible for me to fully equip doctors who are limited by small 12-foot examining rooms. What's more, I know my Imperial owners get satisfaction from our G-E nameplate. Everyone recognizes this symbol of quality — laymen and professionals alike."

THE REGENT

"Many I talk to describe the Regent as the backbone of their x-ray department," explains R. D. Newell, Providence, R. I. "It's really amazing how this one stands the gaff of hard use, day-in, day-out. My installations show a consistent history of solid performance with little attention. My radiologist friends like the smooth, adjustable-speed angulation through 45° Trendelenburg . . . the obstruction-free design . . . Regent's convenience for consultations and resident training. What does it take to interest a radiologist in a Regent? Just the chance to try one, I find."

Your own G-E x-ray representative stands ready to give you helpful information on all these fine General Electric products. Talk to him soon. Or you can obtain illustrated literature by writing X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, Room H-91.

partner...

THE ARISTOCRAT

"I call the Aristocrat a *lot* of x-ray equipment for the price," says J. W. Heller, Topeka, Kan. "I often recommend its economy for both private and hospital practice — who can match it? Full diagnostic range... 15° Trendelenburg table... overhead tube hanger... automatic spot-film device... sealed spot-film phototimer. Aristocrat has the features radiologists need! They like the full-size table too... aren't forced to shove patients into freak positions. Of course, they also appreciate the backing of traditional General Electric cooperation when they need to call on us."

THE PATRICIAN

"The Patrician's low cost comes as a big surprise to many radiologists," says T. B. Moore, El Paso, Texas. "... Makes it easy for me to fit a new G-E unit into the most modest budget. And here's a natural where hospitals want to increase patient-handling capacity. Just as low-cost autos encouraged two-car families, the Patrician makes it really practical to add an extra x-ray unit. Look at what it offers — full-size table . . . independent tube stand . . . rotating anode tube . . . fluoroscopic screen or spot-film unit. With 200-ma power, it can be purchased at a price that makes it foolish to settle for less!"

Progress Is Our Most Important Product

GENERAL ELECTRIC

For additional information, use postcard on page 279.

"BUT, FELMLEY... DON'T YOU THINK A BLAKESLEE DISHWASHER WOULD BE A LITTLE MORE PRACTICAL?"

CHOOSE A BLAKESLEE DISHWASHER FOR FAST, EFFICIENT CLEANING

Recommended for establishments feeding from 50 to 1200 persons per meal

Keeping abreast with the fast, modern-day pace is important to all feeding establishments . . . from the corner restaurant to the large hospital. A Blakeslee Automatic Dishwashing Machine can play a vital role in economically increasing the efficiency of your operation, too.

A Blakeslee Dishwasher is the cost-cutting answer for providing an adequate supply of sparkling and sanitary china and glassware . . . even during peak rush hours.

Think of the time and labor savings! You just place your soiled dishes in a rack—place the rack on the automatic conveyor—dishes pass through a powerful wash—through a thorough rinse—and in only a matter of seconds are ready for use again.

For the dishwasher best suited for your particular operation, a Blakeslee Sales-engineer will make sound, money-saving recommendations.

Twenty-two Models To Choose From (Model EC4 pictured above handles dishes from 50 to 400 persons per meal)

Dept. 117-B

G. S. BLAKESLEE & CO. 1844 S. Laramie Ave., Chicago 50, Ill.
NEW YORK · LOS ANGELES · TORONTO

FREE OFFER!

to prove that Instant Maxwell House is better for <u>your</u> operation than ground coffee!

The experience of successful users of Instant Maxwell House Hotel and Restaurant Coffee has proved that it is better than ground coffee for food service operations. Instant Maxwell House H&R Coffee was developed especially for the food service industry. We want you to try a free supply because we know you'll continue to serve it. And here are the reasons why:

- Instant Maxwell House has *uniformity of flavor*. Day in, day out, you can serve the same delicious cup of coffee!
- Instant Maxwell House offers *substantial economy*. Gives 10% greater yield. No coffee is wasted in grounds.
- Instant Maxwell House *can be made by anyone*—with your present equipment or in a special instant coffee machine, if you desire.
- Instant Maxwell House *saves labor*, eliminates 3 out of every 4 man-hours now spent in preparing ground coffee.
- And—Instant Maxwell House has proven consumer acceptance—it is *America's largest-selling coffee!*
- It is conveniently packaged in urn-size, glassmaker-size, and individual envelopes.

Yes, Instant Maxwell House is better for <u>your</u> operation than ground coffee—and you can prove it for yourself! Mail the coupon below for a FREE one-day trial supply of coffee and demonstration. There's no obligation to buy.

A Product of General Foods

GF INSTITUTIONAL PRODUCTS DIVISION

GENERAL FOODS CORPORATION
INSTITUTIONAL PRODUCTS DIVISION
WHITE PLAINS, N. Y.

Post CEREALS

INSTANT SANKA COFFEE

Log Cabin Syrup

good seasons
SOUP BASES AND SEASONINGS

MAXWELL HOUSE COFFEE

JELL-O DESSERTS

FREE OFFER

General Foods Corporation
Institutional Products Division
White Plains, New York

We're interested in a free one-day trial supply of Instant Maxwell House H&R Coffee and a demonstration. I understand we are under no obligation to buy.

Name.....Title.....

Organization.....

Address.....

City.....State.....

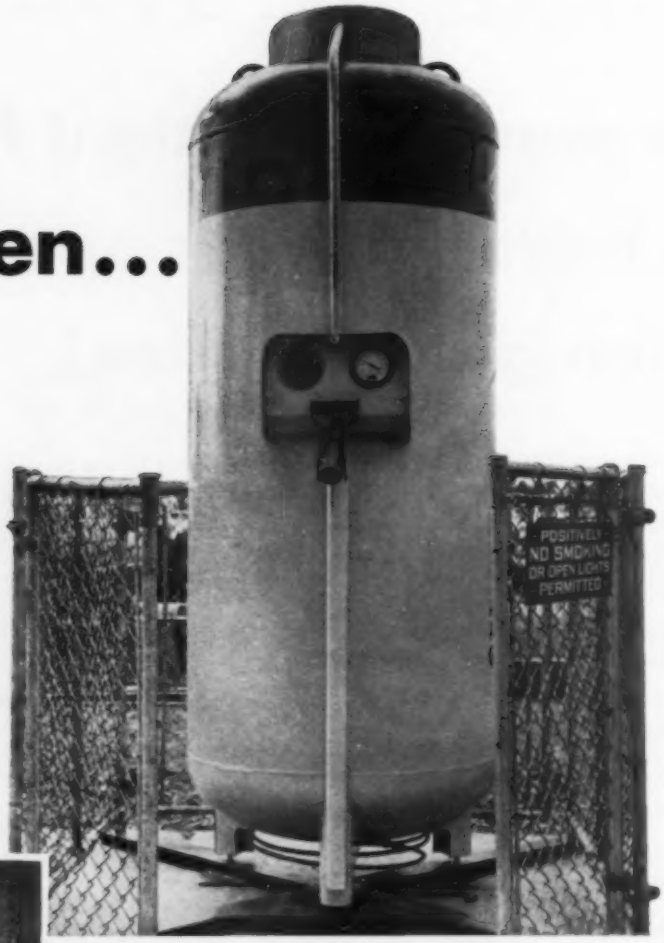
Equipment used (check one) ☐ Urn ☐ Glassmaker

Number Cups Served Per Day

OFFER EXPIRES MARCH 31, 1959 Dept. V

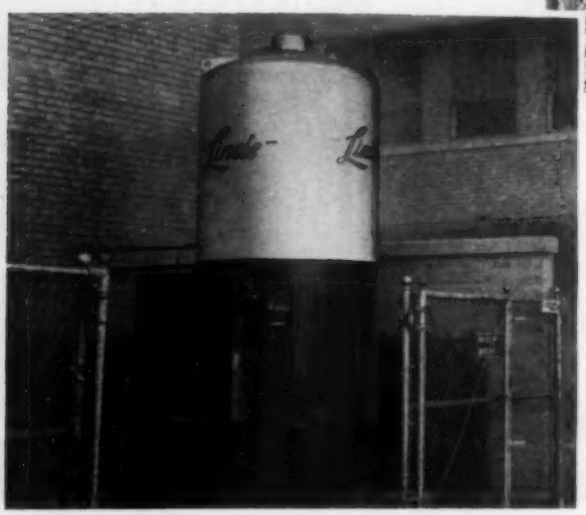
For Liquid Oxygen... *It's LINDE!*

More hospitals can now enjoy the advantages of liquid oxygen storage. LINDE'S *expanded service* provides three distinct supply systems that meet the needs of large, medium and smaller oxygen consumers.



ATX LIQUID STORAGE AND CONVERTER

A *new* LINDE system with 25,000 cu. ft. capacity—brings advantages of a liquid supply to hospitals that could not before utilize liquid oxygen. Constantly supplied and maintained by LINDE or your local LINDE distributor.



VCC-90 LIQUID STORAGE AND CONVERTER

Provides ample liquid oxygen for larger users. Unit contains equivalent of 90,000 cu. ft. of gaseous oxygen.

LC-3 LIQUID CYLINDERS

Convenient, easy-to-handle cylinders of liquid oxygen, each holding the equivalent of 3000 cu. ft. of gas. Can be manifolded to provide a continuous supply to a piping system or can be used at the bedside.

To learn more about the convenience, efficiency, and economy of these liquid oxygen systems, just call your nearby LINDE distributor or LINDE office. Or write to Dept. F-9, LINDE COMPANY, Division of Union Carbide Corporation, 30 East 42nd Street, New York 17, N. Y. Offices in other principal cities. *In Canada:* Linde Company, Division of Union Carbide Canada Limited.

Linde TRADE MARK

UNION CARBIDE

The terms "Linde" and "Union Carbide" are registered trade-marks of Union Carbide Corporation.

Serve your meals WITH Shampaine ELECTRIC

Super-Mealcart. (Design Pat. Pending) (S-3010-MR Illustrated 20 Trays with Beverage Bar S-3010)

SUPER-MEALCART

Represents the latest advance in efficient portable food service equipment for centralized tray systems. The famous step-down feature (design pat. pend.) provides work surface for set-up and beverage dispensing from exclusive removable beverage bar (S-3010). Large drawers with generous clearance allow room for half-pint milk containers and full complement of dinnerware. Drawer depth in hot side permits clearance for coffee cups. Coffee is dispensed from beverage bar into pre-heated cups. Available in *mechanical refrigeration* and *cartridge type refrigeration* models.

MECHANICAL REFRIGERATION MODELS

Mechanical refrigeration with hold-over cooling capacity for a full hour *without* running compressor or blower. Will hold and retain 38° F. even in room temperature of 90° F.

S-3001-MR	(20 trays)
S-3002-MR	(24 trays)
S-3003-MR	(30 trays)

CARTRIDGE TYPE REFRIGERATION MODELS

(CARTRIDGES NOT INCLUDED)

S-3001-DP	(20 trays)
S-3002-DP	(24 trays)
S-3003-DP	(30 trays)

ONLY SHAMPAINE ELECTRIC SUPER-MEALCART HAS . . .

- **an unobstructed set-up area** *convenient* counter height, at 41" for 20-meal cart, at 44" for 24-meal cart. Accommodates large trays up to 15½" x 20½".
- **all stainless steel, double-walled, fully-insulated construction throughout.** 2½" insulation between hot and cold compartment.
- **compact heated drawers** accommodating three 9" dinner plates, *plus* three 5¼" plates, *plus* three coffee or tea cups
- **an oven compartment** with internal, waterproof installed, stainless steel, sheathed sealed heaters. Accessible *without* dismantling or turning cart upside down. Provides uniform temperatures (185° F.) throughout compartment.
- **fully-insulated, recessed and double-walled doors** of oven compartment close tightly against recessed frame. Full-length *stainless steel* piano hinges on doors.
- **rugged, compact tray slides** that can be removed in easy to clean *sections*, providing clearance between tray slides of 3¾" for ½ pint "carton-type" milk container.
- **models in 20, 24 and *30-meal size,** for both *mechanical* and *eutectic* refrigeration (Dole cartridge), and with or without beverage dispensers.

*at additional set-up charge.

S-3010 Beverage Dispenser
(Cart Not Included)

REMOVABLE BEVERAGE BAR S-3010

Removable, easy to load, easy to clean beverage bar with *separate*, individually insulated wells permitting dispensing of boiling water from one and cooled drinks from the other. Bar can be used in combination with utility truck for "between-meal" coffee or fruit juice servings to patients or can be set up in Doctors Lounge.

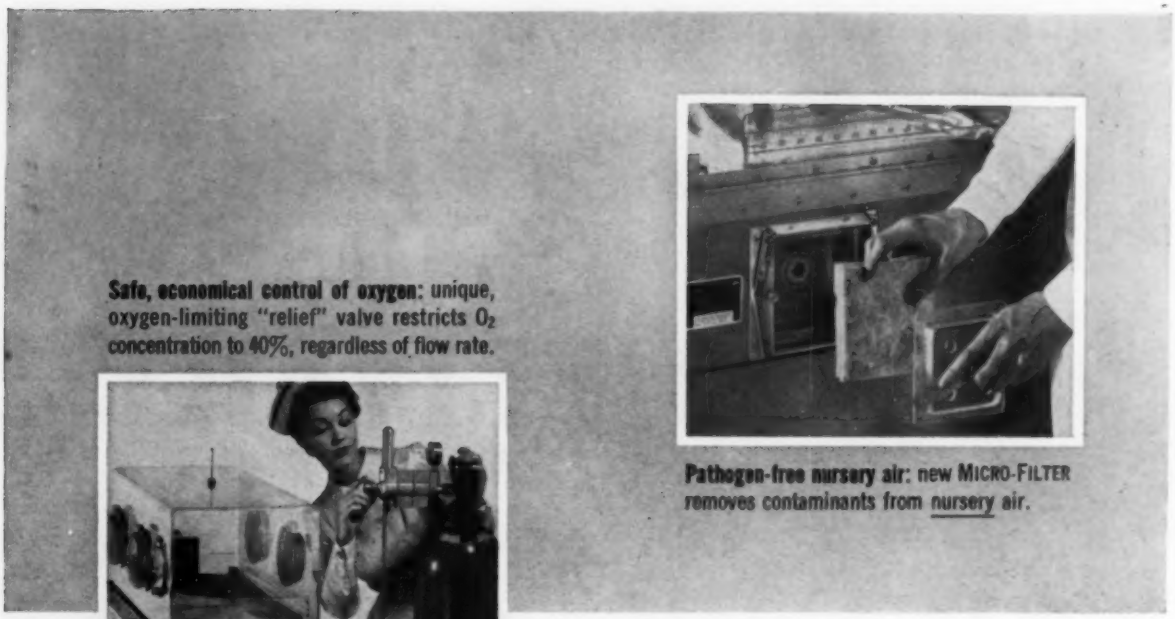
Electric, three well—each well individually thermostatically controlled, stainless steel.

SHAMPAINE ELECTRIC COMPANY, INC. *THE COMPLETE FOOD CONVEYOR LINE*

50 Webster Ave. • New Rochelle, N. Y.

a SHAMPAINE industry

For additional information, use postcard on page 279.



Safe, economical control of oxygen: unique, oxygen-limiting "relief" valve restricts O_2 concentration to 40%, regardless of flow rate.

Pathogen-free nursery air: new MICRO-FILTER removes contaminants from nursery air.

Outstanding features

Removable power unit: compact, lightweight —is easily and quickly removed for cleaning or replacement of parts.

Easy to clean: newly designed conditioning chamber—a one-piece, smooth aluminum casting is quickly and easily cleaned.

THE **NEW ISOLETTE®** PROVIDES—

- True isolation
- Ease of cleaning
- Precise control of environment
- Unique O_2-limiting valve
- Removable power unit
- Molded plastic entry ports

The new model C-77 Isolette infant incubator has been designed to provide many important new features while retaining all the precise atmospheric controls of the earlier model. In addition all ISOLETTE accessories—the VAPOJETTE®, ISOLETTE ROCKER, and weighing scale—fit the new C-77 ISOLETTE.

of the NEW *Isolette®*

infant incubator by *AIR-SHIELDS, INC.*

To provide every advantage for the new-born or premature infant . . .

THE NEWLY DESIGNED ISOLETTE infant incubator (Model C-77) retains and refines *all* the outstanding advantages of the earlier model, and provides many important new features as well:

True isolation—(1) by use of air from *outside* the hospital or, (2) by use of the new MICRO-FILTER which removes 99.50% of contaminants as small as 0.5 micron (average *staphylococcus* is 0.8 micron*) from *nursery* air. Thus, a constant supply of pathogen-free air from outside the hospital, or micro-filtered nursery air safeguards the infant from air-borne or droplet infection.

Easily cleaned—one-piece, smooth aluminum conditioning chamber, with rounded inside corners—no inaccessible areas to become contaminated with bacteria.

Relative humidity control—simple to operate and easy to clean—maintains stable R.H. as high as 85% to 100%, independent of temperature.

Temperature control within $\pm 1°F$.

Efficient cooling system ensures safe incubator temperatures even when nursery temperature exceeds 95°F.

Unique O_2-limiting valve—restricts concentration to 40% even when high flows are used by unique "relief" valve which bleeds excess oxygen outside the ISOLETTE. Low or high concentrations can also be maintained.

Removable power unit—compact, lightweight power unit containing heating element, operating and safety thermostats, and air-circulating blower fits snugly into conditioning chamber. The new power unit is easily removed for replacement of parts.

For additional information about the *new, model C-77* ISOLETTE, phone us collect (OSborne 5-5200) or write AIR-SHIELDS, INC., Hatboro, Pa.

*Zinsser, H.: Bacteriology, ed. 11, New York, D. Appleton-Century Co., Inc. 1957, p. 244.

For additional information, use postcard on page 279.

first hospital-white nurser

THE FIRST PLASTIC NURSER TO AUTOCLAVE SAFELY AT 250° F.

SAFETY—Feed-Rite Nursers are unbreakable, non-allergenic, resist bacteria, will not warp or distort even under steam pressure up to 250°F. Will not absorb odors or stains. Smooth inside surface washes easily.

PROTECTION—Independent laboratory tests† prove Feed-Rite plastic nipple covers a most effective cover for terminal sterilization of formula—offer complete sterile protection of nipple and formula from airborne contamination.

ECONOMY — Bottle, collar, and nipple cover of MARLEX plastic withstand repeated sterilization, can last for months. No breakage means fewer replacements, less possibility of accidents and clean-ups.

*We challenge you to test the new Davol Feed-Rite Nurser

Scores of hospitals have tested them, and are amazed at the durability of the **Feed-Rite** Nurser—made from amazing MARLEX rigid polyethylene.

***FREE:** A test supply of 4 oz. Feed-Rite Nursers with nipple covers will be sent to Nursery Supervisors or Hospital Administrators on request. Write to: Davol Rubber Company, Providence 2, R. I. (on institution stationery), or contact your hospital supply dealer.

† Reports of laboratory tests retained in files of Davol Rubber Company

DAVOL RUBBER COMPANY PROVIDENCE 2, R. I.

made of pure MARLEX*

Amazing properties of new polyethylene make Davol Feed-Rite Nurser ideal for true hospital method of terminal sterilization.

FEED-RITE PLASTIC NURSERS and formula can be terminally sterilized (all at once) under live-steam pressure with the nipples fully covered, in an upright position, ready for feeding. WILL NOT BREAK, CRACK, WARP OR DISTORT.

ORDINARY PLASTIC NEW FEED-RITE

MARLEX rigid polyethylene opens a new era in plastics, with numerous advantages over conventional materials now in hospital use.

- **VIRTUALLY INDESTRUCTIBLE** . . . Products made of MARLEX plastic are tough and strong! Throw the FEED-RITE NURSER on the floor, step on it . . . try to crush or break it, and you'll see what we mean.
- **BETTER TEMPERATURE RESISTANCE** . . . You can freeze MARLEX at temperatures as low as 180° F. below zero without damaging it . . . and heat it up to as high as 250° F.! You can boil or steam-sterilize the FEED-RITE NURSER and other MARLEX products.
- **EASY TO CLEAN** . . . The hard, glossy surface of this new material has superior abrasion resistance and is very easy to clean and maintain.
- **GREATER CHEMICAL RESISTANCE** . . . MARLEX is unaffected by most acids, alkalies, detergents, greases or oils. It has very low permeability to most liquids and gases, and is non-absorbent and waterproof.
- **NON-ALLERGENIC** . . . MARLEX is compatible with all body tissues. Can be used for surgical sutures, tubes and prosthesis materials.
- **TASTELESS, ODORLESS** . . . Absolutely safe for use as a food container. Will not absorb odors.
- **LIGHT WEIGHT** . . . FEED-RITE NURSERS are easy to hold, comfortable to touch. Most MARLEX products are lighter weight than conventional materials.
- **CORROSION-PROOF, ROT-PROOF, BACTERIA RESISTANT** . . . No matter how long you subject MARLEX to hot, humid tropical-like conditions it never rots, rusts, discolors or mildews. *Bacteria cannot attack it.*

In fact, no other type of material can serve so well and so economically in so many different applications!

**MARLEX is a trademark for Phillips family of olefin polymers.*

Phillips 66

PHILLIPS CHEMICAL COMPANY
BARTLESVILLE, OKLAHOMA
A subsidiary of
Phillips Petroleum Company

LOOK FOR THE MARLEX TAG— YOUR ASSURANCE OF QUALITY AND DURABILITY

MADE OF
MARLEX®
a Phillips 66 Plastic
safe and pure
This durable new plastic can be boiled and sterilized to hospital standards. Holds its shape! Unbreakable!

For additional information, use postcard on page 279.

ONE CONVEYOR...MANY TOP ARRANGEMENTS

All-purpose food conveyor provides interchangeable insets for various menus

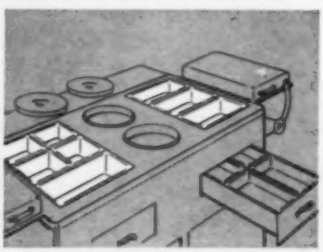
• You are ready for every food service requirement with Blickman-Built all-purpose food conveyors. Simply arrange the different sizes of square and rectangular insets in the top deck to suit the menu. For general service, you store the relatively limited variety of foods in larger insets. To handle the more diversified foods in selective menus and special diets, you replace the larger insets with a greater number of smaller ones. Round wells are also provided for soup, broth and potatoes.

• Seamless top and crevice-free body is standard construction in all Blickman-Built stainless steel food conveyers. These features offer notable benefits in sanitation and durability.

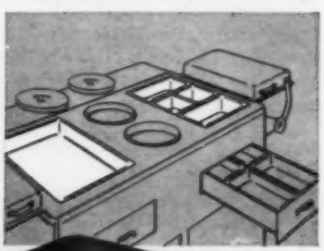
• The new Hi-Flo heating system cuts preheating time in half, assures piping hot foods for your patients.

A full complement of square and rectangular insets provides food storage for a wide variety of menus.

Rectangular wells accommodate a variety of inset combinations.



Another possible arrangement for top deck. Heated drawer holds special diet insets. Round insets are for soup, broth or potatoes.



Another variation showing use of one full-size pan at left and four insets in right-hand well.

All-Purpose Model ALS-4922
Long shelf and two rectangular pan covers provide work surface for loading trays.

SEND FOR CATALOG
Blickman-Built all-purpose food conveyors are fully described in our new Catalog T-5. Also shown are a wide selection of bulk food and tray conveyors designed for various types of decentralized and centralized services. Write for your copy today.

S. BLICKMAN, INC.
1309 Gregory Avenue
Weehawken, N. J.

Look for this symbol of quality... Blickman-Built

BLICKMAN
FOOD SERVICE EQUIPMENT

KYS-ITE® Color-Craft Trays

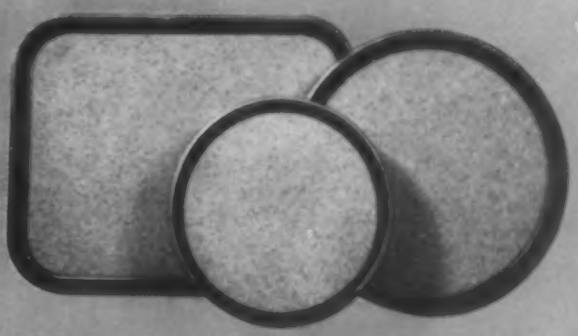
. . . Gay Colors whet the appetite

KYS-ITE Color-Craft molded plastic trays brighten mealtimes in restaurants and institutions. The beautiful patterns and colors are carried over both sides of the trays, and the edges are smooth and closed. The use of a variety of colors has proved popular, particularly in cafeterias, or you can order a single color to harmonize with the décor of your restaurant.

- ★ Choice of two handsome patterns, each available in four colors.
- ★ Extra strong, almost indestructible.
- ★ Stain-resistant, non-corroding, easy to clean.
- ★ Impervious to boiling and to mild acids or alkalis. Guaranteed not to warp.
- ★ Lightweight and quiet in use.

a complete line of trays to fill every need

REGULAR KYS-ITE® SERVING TRAYS
for durability and economy. 10 sizes available in red, brown and rust.



KYS-ITE® CORK-SURFACED TRAYS
for non-skid, safety service. 5 sizes available in red and brown.

Be Wise-Buy

KEYES MOLDED PRODUCTS

MAIL THIS COUPON

Keyes Fibre Company, Waterville, Maine

Please send further information on KYS-ITE, KYS-ITE Cork-Surfaced and KYS-ITE Color-Craft Trays.

NAME .....

NAME OF FIRM .....

ADDRESS .....

.....

FEATURES *here*

here

here

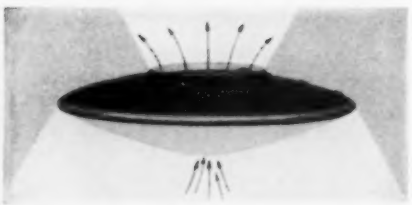
here

...and many more...

explain why everyone approves these new

DAZOR LAMPS

with Fiber Glass Diffusers



Dazor Lamps at top of page are Swing-Arm Pedestal Model 2005 and Table and Desk Model 2003. Just above is Swing-Arm Desk and Table Model 2004. Standard finish is frost-green baked enamel over bonderizing, combined with brass. Optional colors at no extra charge: frost-tan, statuary-bronze, gray or ebony. Lamps with color-matching arms are also available.

The extra lighting convenience, glare-free seeing comfort and distinctive styling of these new matched Dazor Lamps are enjoyed by patients, visitors, staff. They embody the latest lighting concepts. Broad, direct illumination is softened by a fiber glass diffuser. An opening in the bottom emits an undiffused light beam on the reading or writing surface and also admits air for natural ventilation. Each user controls light location and intensity in Swing-Arm models by adjustment horizontally, up or down or at an angle.

Air Cooling... Upper-Level Lighting

A perforated metal ventilator in the reflector top permits rising air to carry bulb heat away for cooler lighting and safe handling. The same perforations release partial upward light which tends to minimize abrupt brightness contrast, thereby reducing eye fatigue. Choose from varied decorator finishes for patient rooms, lounges, offices, nurses' dormitories. Authorized Dazor Distributors and their Dealers will gladly provide details and prices. Investigate now. Dazor Manufacturing Corp., 4481-99 Duncan Ave., St. Louis 10, Mo. In Canada, Amalgamated Electric Corporation Ltd., Toronto 6, Ontario.

ONLY QUALITY FIXTURES COME FROM THE MAKERS OF

DAZOR FLOATING LAMPS

FLUORESCENT and INCANDESCENT

no pain . . . no memory

no nightmare of fear

in pediatric anesthesia

PENTOTHAL®
(Thiopental Sodium, Abbott)
sodium

Sparing the child from emotional trauma in surgery can be advantageous to the physician as well as the patient. When the child has no memory of the operating scene, post-surgery complications are lessened and recovery becomes just that much more certain. With Pentothal administered rectally, you have a most practical, yet notably safe and simple, approach to pediatric anesthesia. Abbott


MAIN

Reliability in Action

The vocabulary of hospital solution users has changed.

You don't hear much talk about problems of pyrogens, sterility, precipitation, or the like—any more. Modern factory techniques of solution manufacture have relegated such subjects to the textbooks.

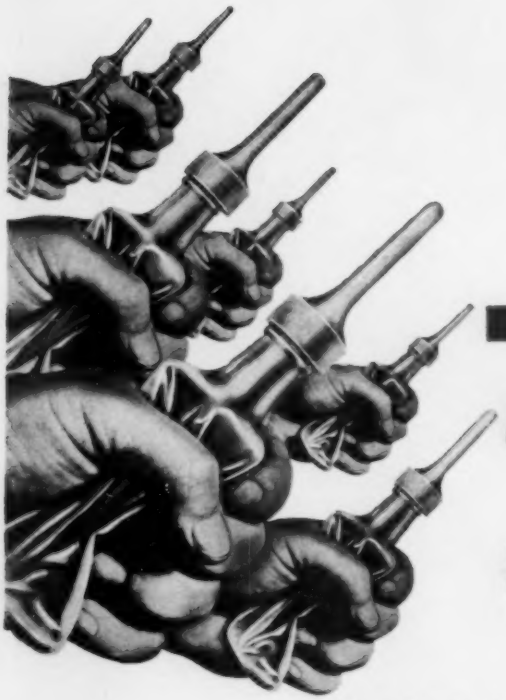
But make no mistake. Abbott has found no short-cuts. The savings of mass production simply enable us to lean over backwards in the safeguards we impose on every bottle.

We can't afford anything that is second best. Neither can you. Why not talk over your hospital solutions needs with your Abbott man . . . soon.

Abbott Parenterals

SOLUTIONS AND EQUIPMENT

Would you like a print of this Tom Allen painting, "School Guard," on wide-margin paper for framing? Write Professional Services, Abbott, North Chicago, Ill.



7 FLEET® ENEMA

Disposable Units *

may be administered in the time required for 1 soap suds enema.[1]

administrators like *FEDU

because FLEET ENEMA Disposable Units save time and money.[1]

physicians like *FEDU

because the 4½ fl. oz. unit is more effective than one or two pints of soap suds,[2] and the anatomically correct rectal tube minimizes injury hazard.[3]

personnel like *FEDU

because FLEET ENEMA Disposable Unit is ready to use, even to the pre-lubricated rectal tube. Eliminates preparation and "clean-up."

and patients like *FEDU

because FLEET ENEMA'S combination of 16 Gm. Sodium Biphosphate and 6 Gm. Sodium Phosphate is gentle and the small amount of solution seldom causes pain or griping.

1. "Standard vs Disposable Unit Enema": Rainier, W. G.: and Lee, B., Hospitals 31:50, Jan. 1, 1957
2. Swinton, N. W., Surg. Clinics No. Am. 35:833, 1955
3. Palmer, E. D., "Clinical Enterology," Hoeber-Harper, 1957

and now **OIL RETENTION ENEMA** (FLEET)*

each single use disposable unit contains 127 cc. Mineral Oil USP.

Write for free copy of Rainier-Lee Time-Cost Study, Samples and Price List

since 1869 Fleet

C. B. FLEET CO., INC., Lynchburg, Virginia

makers of Phospho-Soda (FLEET)

In Canada: Produced by Charles E. Frosst & Company

SOFT

...with the gentleness of fine home tissue
...good-will builder in the washroom

Fort Howard Paper Company

Green Bay, Wisconsin

America's most complete line of paper towels, tissues and napkins

A NEW HILL-ROM SERVICE

A Series of Procedure Manuals

Hundreds of thousands of these practical teaching aids have been distributed

FREE

to Hospitals

and Schools of Nursing

to inform nursing personnel regarding the effectual use and care of modern hospital equipment . . .

PROCEDURE MANUAL No. 1

"SAFETY SIDES—A PROVEN SAFETY MEASURE"—Contains detailed information about short side guards, and how they have reduced bed-fall accidents in hospitals across the country.

PROCEDURE MANUAL No. 2

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About the Author: Alice L. Price, R.N., M.A., B.S. degree from Purdue, Master's degree from Wisconsin. Four years resident Nurse Women's Residence Halls, Purdue; Three years Counselor, School of Nursing, Presbyterian Hospital, Chicago; Nursing Arts Instructor and Director of Nursing, several leading Midwest hospitals; Author of "The Art, Science and Spirit of Nursing," recognized as the leading textbook on Nursing Arts in U. S. and Canada, also other text books. Three years Nurse Consultant for Hill-Rom Co.

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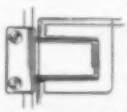

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FASOULIA

SERVINGS: 48 (¾ cup each)
PRODUCTS: Magic Onions, Tomato Soup, Ketchup

INGREDIENTS	WEIGHT	MEASURE
*Magic Onions	1½ ozs.	1 cup
Water		1 cup
Ground beef or lamb	8 lbs.	
Shortening		¼ cup
Salt		¼ cup
Heinz Condensed Cream of Tomato Soup, undiluted		1 51-oz. can
Heinz Tomato Ketchup		1 quart
Cooked green beans	5½ lbs.	1 gallon

Cover onions with water; allow to stand 20 minutes. Brown beef and onions in shortening. Add salt and remaining ingredients. Heat.
*1 quart chopped, fresh onions may be substituted; omit water.

JAMBALAYAH

SERVINGS: 50 (¾ cup each)
PRODUCTS: Magic Onions, Tomato Soup, Ketchup, Worcestershire Sauce

INGREDIENTS	WEIGHT	MEASURE
Green shrimp	12½ lbs.	
*Chopped Magic Onions		1¼ cups
Water		3½ cups
Celery, chopped	2 lbs.	2 quarts
Green pepper, chopped	1 lb., 6 ozs.	5 cups
Shortening	8 ozs.	1 cup
Heinz Condensed Cream of Tomato Soup, undiluted		3 51-oz. cans
Heinz Tomato Ketchup		1 quart
Heinz Worcestershire Sauce		¾ cup
Salt		1 tablespoon

Cook shrimp; remove shells; devein. Cut in half lengthwise. Cover Magic Onions with water; allow to stand 20 minutes. Cook celery and green peppers in shortening until tender. Combine shrimp, vegetables, soup and remaining ingredients. Heat over low heat or in steam-jacketed kettle. Serve over hot, fluffy rice.
*7 cups chopped fresh onions may be substituted. Omit water.

For additional information, use postcard on page 279.

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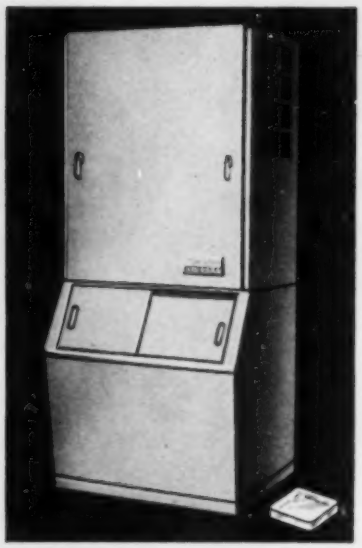

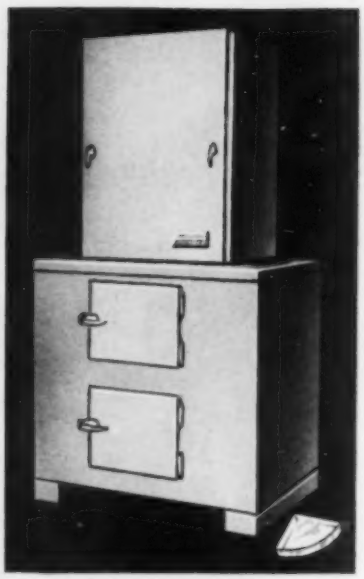

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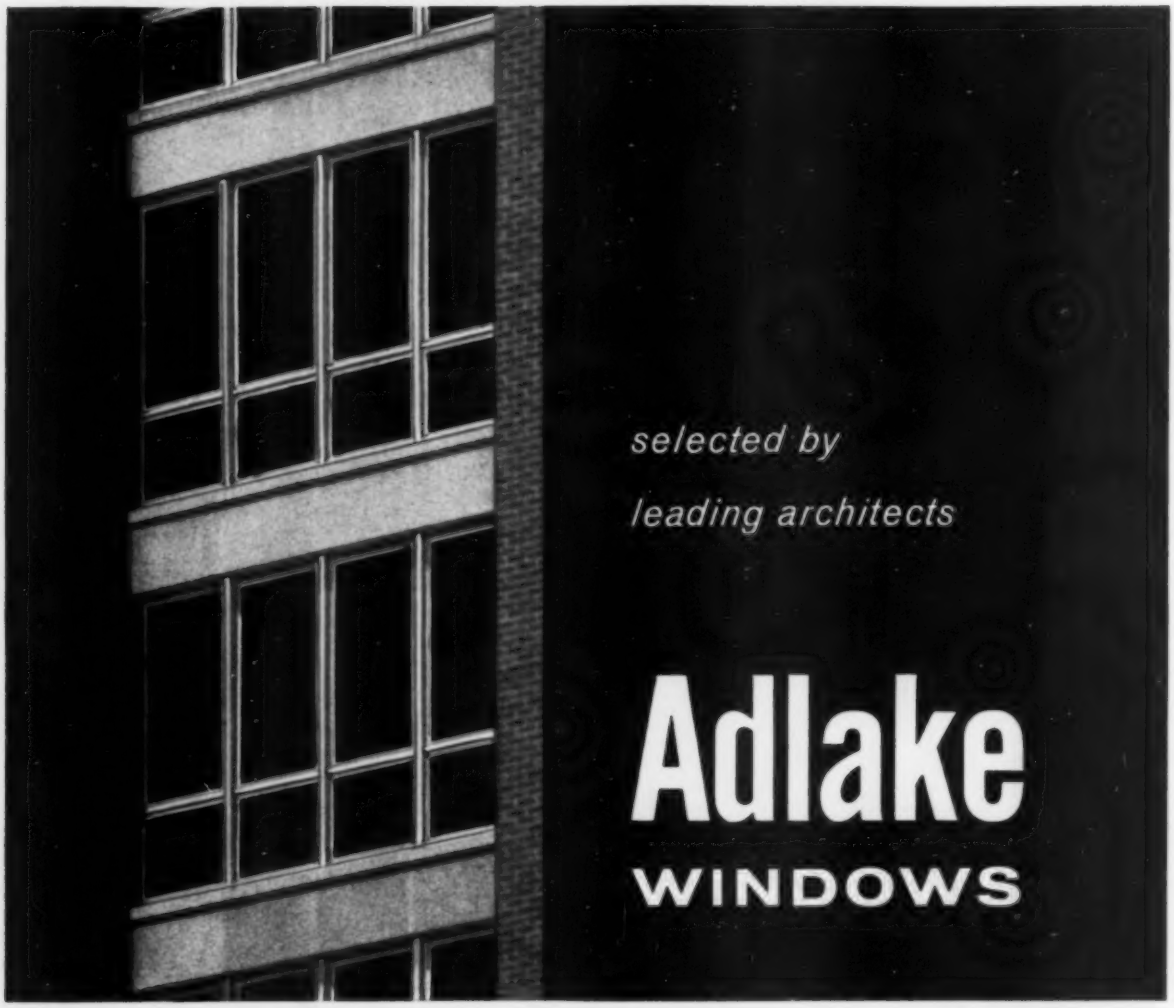

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SMALL HOSPITAL·QUESTIONS

Ethics of Drug Exhibits

Question: We have been asked by several pharmaceutical representatives calling on our hospital if we will permit them to exhibit their new products at the hospital and discuss the products with our staff members while they are here. We are a new hospital and are not certain if this practice is ethical and acceptable among hospitals generally. What is the policy in other hospitals?—B.G., Okla.

ANSWER: In a recent survey, 482 of 653 hospitals of all sizes and types stated that they do provide space for technical exhibits of pharmaceutical products when requested to do so by the manufacturers' authorized representatives. In most cases, the administrator approved the request — in cooperation with the pharmacist in about half the hospitals, and, in some cases, with approval of the pharmacy committee of the medical staff. To avoid misunderstanding, it is wise to have an understanding with representatives of the exhibiting company, in advance of the exhibition, covering the kind of display that will be presented, its location, the hours the new product will be on display, distribution of samples, and other details of the presentation. Also, hospitals have found it expedient to insist that manufacturers' representatives remain in the display area to discuss the products with members of the medical staff who may visit the exhibit. This is to avoid embarrassment or annoyance caused by the occasional representative who may wander through the hospital buttonholing busy doctors to talk about his products. Most reputable manufacturers have their own rules for proper exhibit procedure and are glad to comply with whatever policies the hospital may wish to establish, however.

How to Break Even

Question: Is there an established or recognized "break-even point" for a 25 bed hospital? That is, how many patients does the average hospital of this size have to have in order to earn operating expenses?—L.B., Calif.

ANSWER: The "break-even point" for any hospital depends on a number of variable factors, in addition to occupancy alone. Charges in relation to cost, use and charges for ancillary and stand-by facilities, staffiing, number of patients using such services as emergency room, operating room, labor and delivery rooms, and nursery, and many other factors must all be considered in the profit and loss picture. Generally speaking, however, it is probably true that the "break-even point" in occupancy for the average hospital of 25 beds is 17 or 18 patients.

Doctors on the Board

Question: One member of our medical staff insists that it is the policy of the American Medical Association, American College of Surgeons, and other official bodies that there should be doctor-members of the hospital's board of trustees. Is it true?—P.S., Ill.

ANSWER: No. In a statement of principles of the relationship between hospitals and physicians approved several years ago by the American Medical Association and the American Hospital Association, physician membership on hospital boards of trustees was included as one of several acceptable methods of maintaining proper liaison between the medical staff and governing board, but neither the American Medical Association nor the American Hospital Association has a policy specifically approving or advocating such membership. Recently, the board of governors of the American College of Surgeons approved a resolution recommending to the board of regents of the College that physician membership on hospital boards of trustees should be advocated by the College. The board of regents, however, which is the policy-making body of the American College of Surgeons, did not act on the resolution, taking the position that the College as a scientific and educational society should not properly take a position on this question.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

M.D.'s Collect Bills?

Question: A trustee of our hospital is urging the board to consider adopting a policy under which doctors would be required to assume financial responsibility for charges incurred by patients admitted under their care. Is this a good policy?—R. T., Tex.

ANSWER: It is a bad policy and might disastrously interfere with the physician's freedom to practice medicine as he sees fit, according to the medical needs of his patient. The physician should certainly be expected to give the hospital as much information as he may have about the financial position and reliability of his patients who are hospitalized, and, on occasion, a physician may voluntarily assist in the collection of a hospital bill, where such participation does not interfere with medical aspects of the physician-patient relationship. But it is unreasonable for the hospital to make the physician responsible for collection of patients' charges, and it is not known that any hospital — with the possible exception of some that are owned and operated by physicians for their own profit—has such a policy.

Discard Differentials?

Question: We are still charging different rates for the operating room, anesthetic, laboratory, x-ray examination, and other special services for patients in private, semiprivate and ward beds. Recently I read or was told that this practice is outmoded and it should be discarded. Is this true?—C.J., N.Y.

ANSWER: The accepted view among most hospital authorities today is that the charges for such services as these should be established on the basis of cost for rendering such service, and that differential rates for patients in various types of accommodations are therefore improper. In a recent survey of hospitals, however, about half of those responding still had some rates that varied for private and ward patients, for some of these services.

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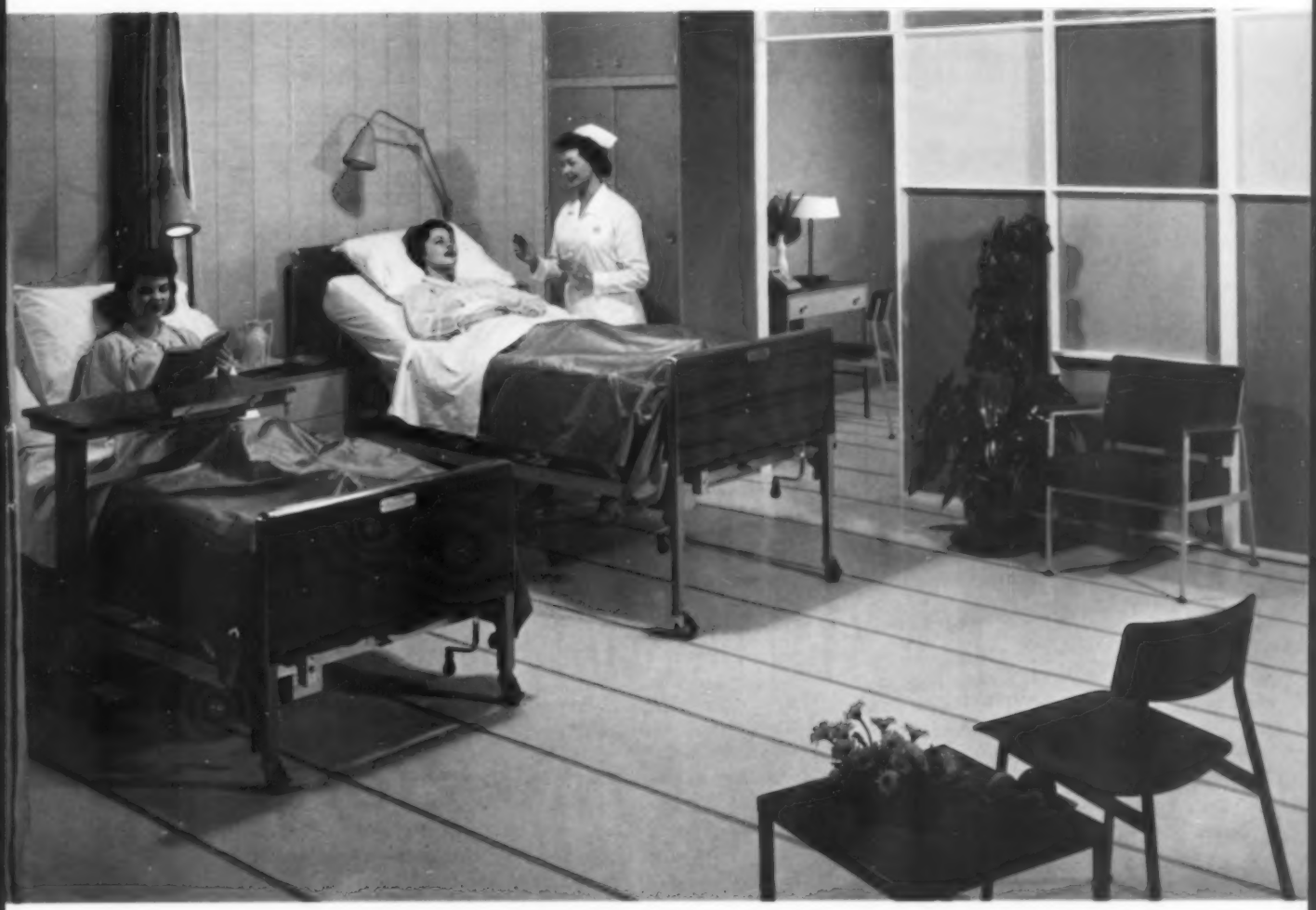

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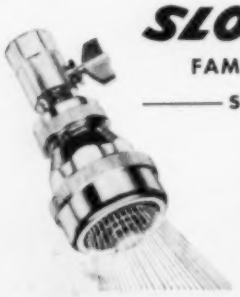

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MEDICARE CUTBACK

The long-suffering 85th Congress, which broke with tradition by staying in session well into August in an election year, made important decisions in the hospital-medical fields in its final turbulent weeks. Here are some of the major ones:

Medicare was cut back in a way that will have a damaging effect on hundreds of hospitals located in areas where there are military medical facilities.

This action was taken despite the dogged fight put up by the American Hospital Association and the American Medical Association to keep the civilian phase of Medicare at about the same level it has followed for the two years since its establishment.

A movement that originated with a very few members of the defense subcommittee of the House appropriations committee built up momentum in the Senate appropriations committee and was only modified on the Senate floor.

The handful of House committeemen became convinced that military hospitals could handle dependents at a cost far less than civilian hospitals charge—and they wouldn't recognize a mountain of evidence, including reports from the Budget Bureau, that this claim was 90 per cent fiction.

These men also were incensed that the Department of Defense, despite instructions from the House committee last year, had done nothing to channel more dependents to military hospitals. Here they had a point that would stand examination — if unused hospital beds have to be maintained for military reasons, certainly there would be a saving if dependents were told to use them or pay their own hospital bills.

Until Senator Knowland took the floor in the Senate late in the evening when the Medicare appropriation was up for a vote, there was no sign of compromise. Had the House idea carried through, the civilian part of Medicare would have been cut back between 60 and 70 per cent.

The Knowland proposal won out. Under it Medicare gets $70.2 million for the current fiscal year for a program that, if run on last year's scale, would cost about $100 million. But, if pinched too hard, Medicare can use other Defense Department funds or come to Congress early next year for a deficiency appropriation. If the House group had had its way, the appropriation would have been $60 million, and not a penny more than that could have been spent.

However, to appease the Representatives, the joint conference committee wrote into its report instructions that the department stay within the $70.2 million. While this does not have the force of law, the department will try to comply by a number of restrictions, all designed to force more dependents into military hospitals.

Dependents living with sponsors are being ordered to use military facilities, if there is room for them.

If not living with sponsors, the families will have freedom of choice between civilian and military hospitals, as in the past.

Maternity patients living apart from sponsors also will have freedom of choice.

Maternity patients living with sponsors will be subject to the following restrictions: As of October 1, new and first trimester patients must use military hospitals if there is room; second and third trimester patients, if under civilian care, may continue, but if they change physicians for any reason the military authorities will decide where they should receive their care.

All medical services "not clearly specified by law" will be discontinued for dependents in civilian hospitals. These include treatment of nonhospitalized injuries, terminal visits (generally when patient is changing doctors), tests before and after hospitalization, the two "well baby" visits, nervous and mental diseases, and elective surgery.

In areas having more than one military facility, military authorities will set up clearing centers that will direct dependents to hospitals in such a way as to make maximum use of all service hospitals.

Military officials announced and explained the above limitations to a glum meeting of Medicare contractor representatives, who were in a "take it or leave it" position. There were some prospects for modifications if protests became loud enough, but the consensus was the limitations were here to stay.

RESEARCH BUILDING GRANTS

The possibility that hospitals and medical schools would to be brought into a new federal grants program came to an abrupt end.

In a bill for extending the program of grants for building and equipping medical research plants, the House commerce committee first wrote in a provision that would allow use of the money for "multiple purposes" structures, that combined, for example, research with hospital use or research with teaching.

Then, before the bill was formally presented to the House, Chairman Oren Harris had this provision stricken. He was afraid that in the closing rush even the simple extension bill for research grants would get into trouble if it were expanded in any way that might mean more spending.

Had the provision made its way through the House, there is not much question but what Sen. Lister Hill would have welcomed it in his Senate committee and guided the bill into law.

HEALTH CARE OF THE AGED

While the Forand bill for hospitalization under social security lost out, the Department of Health, Education and Welfare was instructed to study the whole problem of financing of medical care for the aged, with special emphasis on O.A.S.I. payroll deductions to finance medical care insurance after age 65.

The payroll deduction-health insurance scheme is the particular pet of powerful Oren Harris, chairman of the

House ways and means committee. He doesn't think this has any socialized medicine flavor, but if the idea reaches the point of hearings next year, Mr. Harris will meet many witnesses who do think so.

H.E.W. was ordered by the Harris committee to complete its study by Feb. 1, 1959. This was assurance that the Forand and similar issues will receive attention within one month after the new Congress convenes.

The committee said it was "very much aware" that financing of medical care for the aged presents many problems, and that there are strong feelings that health insurance is "out of reach" of too many older people. However, the report went on to say that it wasn't convinced yet that the Forand solution was the best one.

The committee believes a study on the practicability and costs of providing some protection of this nature should be made. Its report says:

"The alternatives explored should include . . . a proposal for a prepayment plan under which persons would, during their working years, pay additional social security contributions . . . to be used to buy this type of insurance . . . to take effect when the individual becomes an old-age, survivors or disability insurance beneficiary."

Insurance would be purchased from either commercial or nonprofit health insurance organizations.

The report had hardly been released when A.F.L.-C.I.O. President George Meany said that while labor was disappointed that the Forand bill wasn't approved, "this cannot be construed as a decision of the Congress to discard this proposal. . . . It is by no means a dead issue. . . . It will be a live issue as long as the problem remains unsolved, and we intend to urge adoption of the Forand proposal along with other measures further to improve the system, as soon as the 86th Congress convenes next January."

PUBLIC ASSISTANCE GRANTS

A number of states that were having trouble trying to pay hospitals and doctors directly from public assistance funds were rescued from the financial pinch.

The new Social Security Act contains authority for the states to use the federal grants in any way they want—direct payments to the assistance cases or pooled to make up a state fund. In other words, from now on states may use the federal share for either general maintenance or for medical payments.

VETERANS HOSPITALS

The House veterans affairs committee publicly announced that it had not given up in its fight to force the Budget Bureau to authorize more beds for V.A. hospitals.

Chairman Teague's committee, getting in the last word in its feud with V.A. Administrator Sumner G. Whittier, reported out a bill that would direct V.A. to operate 125,000 beds, instead of the present 120,526. For months Mr. Whittier has stalled out the issue, meanwhile not giving V.A. the go ahead signal on the 5000 beds.

The bill also would (a) write into law the regulation requiring a financial statement from veterans with nonservice connected conditions who apply for hospitalization, (b) require V.A. to notify the committee at least 90 days in advance (and during a session of Congress) of any plans to shut down a hospital, (c) permit the V.A. administrator to refuse hospital care to a nonservice case carrying workmen's compensation or similar insurance if other eligible veterans are waiting care, and (d) permit V.A. to furnish outpatient care for nonservice cases where necessary to determine if hospitalization is required or to complete treatment incident to hospitalization.

Mr. Teague clearly was engaging in a legislative exercise; his bill was offered so late as to be completely out of the running for this year.

HILL-BURTON

The Hill-Burton hospital construction program had a perfect score. In addition to voting a record $186 million for hospitals, clinics and so on, Congress decided to give the program a five-year extension. This means it will continue without the usual biannual extension worries at least until July 1, 1964.

The House committee had considered some modification in H-B, but finally decided to let it go on as it is for another year. The Department of Health, Education and Welfare was preparing some recommendations for next year, but didn't have them in final form by the time the adjournment rush was on. It is understood that H.E.W. later will ask Congress to combine chronic illness facilities and nursing homes into one category of long-term care institutions, and will propose less emphasis on diagnostic-treatment centers.

ANNUITIES FOR SELF-EMPLOYED

Congress toyed with the Keogh bill for annuity assistance for the self-employed for months, then the Senate neatly dropped it in a heap and in such a way that no one could be accused of voting against tax assistance for doctors, lawyers, and so on.

The bill — allowing a tax-free setaside in a pension fund of up to $2500 per year — came out of the House committee on a divided vote, but sailed through the House by an overwhelming majority, built up by pressure from the self-employed.

The Senate was another story. Chairman Byrd of the finance committee was in no hurry to report out the bill, but effort was made on the Senate floor to make it a part of another tax bill by amendment.

Senator Morse then offered a substitute amendment, one that would cost the treasury possibly $2 billion in income and for this reason had no chance of passage. Next step in the strategy was for Senator Kerr to challenge both amendments as not being germane. The chair ruled that they were germane. Then Kerr insisted on a roll call in an attempt to reverse the chair's ruling. The chair was reversed, 52 to 32, and both amendments were then out of order.

Any Senator who might have been pledged to the Keogh bill could have, under these circumstances, voted against it, yet defend himself on the grounds he was voting against the Morse amendment, or that he believed either one or both of the amendments (a) was not germane to the bill under consideration, or (b) should follow the usual legislative course up through the finance committee.

Thus the doctors and others who might feel the deck was stacked couldn't prove it.

NOTES:

Legislation for federal guarantee of proprietary nursing home mortgages lost out when the House rules committee brazenly refused to act on the bill, even though it had been approved by another committee. When an effort was made to put it through under special procedure, the bill couldn't muster the two-thirds House majority required.

Nursing accreditation, social security and progressive care were the things they talked about at the A.H.A. convention last month, along with heat and humidity in the exhibition hall and hallelujah for the new headquarters building (right)

Ptotograph by David Kendall.

Photograph by McShane Studios.

"For Sale" sign on the old headquarters building of the American Hospital Association (left) indicates the imminence of the move to the new building (above) which is presently scheduled for occupancy on December 1.

THE YEAR THE A.H.A. DREAM CAME TRUE

Dream

CHICAGO. – Seeing a dream fulfilled, 2500 members of the American Hospital Association forgot that the dream had sometimes been a nightmare and looked on happily, *via* closed circuit television, as the association's new $7,800,000 headquarters building was dedicated on the opening day of the 60th annual A.H.A. convention.

"Much planning, money and hard work have set the stage for this occasion," said George Bugbee, former executive director of A.H.A. and principal speaker at the dedication. The fact that it took a lot more planning, money and hard work than anybody thought would be needed was referred to briefly by another dedication speaker, association treasurer and building committee chairman, John N. Hatfield. "The road was not always clear," he said. "A weaker, less dedicated membership might have turned away."

Watching the ceremony on a huge TV screen in the arena of the International Amphitheatre, the members obviously felt rewarded for all their pains and dues and applauded lustily when George Bugbee pulled the drapery from the A.H.A. seal on a lobby wall of the new building, with these words: "By this act, I now pledge this American Hospital Association headquarters building to our inspiring purpose here emblazoned on the wall – 'Better hospital care for all the people.'"

Better care for all the people wasn't inspiration enough to hold some of the people in the exhibition hall later in the week, however, when the temperature mounted into the 90's and, as one dripping exhibitor said wearily, you could see the humidity. At the other

DEDICATION OF NEW A.H.A. HEADQUARTERS

Photograph by McShane Studios

George Bugbee speaks at A.H.A. dedication. At his right (front row) are Dr. Roscoe Miller, president of Northwestern University (left) and Tol Terrell, A.H.A. president. Behind them (l. to r.): Hugh Garden, Dr. Guillermo Almenara, and Dr. Edwin L. Crosby. Dr. Otto Bettag and John N. Hatfield at far right.

end of the Amphitheatre, lectures and conferences were well attended – a circumstance that unquestionably owed something to the air conditioning there, as well as to the excellence of the lecturers and conference leaders.

By Thursday morning, registration exceeded 10,000 – somewhat less than the comparable figure for last year but still enough to cause observers in the exhibits to wonder where everybody had got to.

Several hundred interested members, at least, got to sessions of the A.H.A.'s House of Delegates, which were lively and productive as delegates pulled the string on nursing school accreditation, went along nervously with a policy statement suggesting the possibility that the retired aged might need social security help with their hospital bills, and tapped a soft-spoken, 45 year old physician-administrator, Dr. Russell Andrew Nelson of Johns Hopkins Hospital, for president-elect.

Later, debates that began in the House were continued as delegates and members got together in various-sized rooms to talk about nurses, the aged, infections, costs, progressive care and all the other problems hospital administrators are concerned about, on and off convention programs. Whatever the subject, most of the discussions ended earlier than they have other years. As the humidity waxed, the hilarity waned; obedient to requests from A.H.A. and the Hospital Industries' Association, most manufacturers cut down on the lavish entertainment that has been laid on in previous years, and "hospitality suites" were generally closed by early evening.

As they got back to their homes and jobs after the convention, however, it wasn't the austerity, or the humidity, or the arguments, that hospital administrators would remember from their 1958 convention. It was the building – still unfinished, but promised for occupancy in December and already accepted, in George Bugbee's words, as "positive evidence of the concern which we all feel toward continually improving hospital service."

This year would be remembered as the year the dream came true.

We Love You, But

"If they don't play ball – if we have been suckered into something that is improper, we have the opportunity of getting up and yelling to high heaven. We can say, 'Ladies, we love you very much, but we are pulling out!' "

With those prophetic words, Dr. Albert W. Snoke of New Haven, Conn., ended the debate about nursing school accreditation at the annual convention of the American Hospital Association in San Francisco in 1953. Following the recommendation of Dr. Snoke, who was then chairman of the Council on Professional Practice, the delegates over-rode the misgivings of many who predicted that hospital schools would feel the squeeze and voted to go along with the accreditation program of the National League for Nursing.

Last month, they got up and yelled to high heaven. Among other things about the accreditation program, the delegates didn't like the vagueness of accreditation standards, the arbitrary attitude of surveyors, failure to simplify the accreditation process, rigidity of standards respecting the qualifications of nursing school faculties, and, especially, the increasing costs of accreditation and the inspection fee system, which a statement introduced by the California Hospital Association described as "discriminatory, as all hospitals benefit by the hospitals that carry the expense for schools of nursing."

As it turned out, nobody really disagreed with California, and the debate was wholly concerned with details. Eventually, the House:

1. Voted to ask the National League for Nursing and the American Medical Association and "possibly other groups" to join A.H.A. in "establishing as rapidly as feasible" an independent commission on accreditation of hospital schools of nursing (inclusion of collegiate schools was ruled out when a proposed amendment lost by a hairline decision).

2. Instructed the Council on Professional Practice to review the December 31, 1959, deadline date for provisional accreditation of hospital schools and requested the League to "defer the deadline until such review has been completed."

3. Called the proposed new fee schedule for nursing school accreditation "unreasonably high" and urged the League to "adopt every measure possible to reduce the cost of accreditation."

Once these actions looking toward pulling A.H.A. out of the present accreditation program were taken, the delegates remembered to say, "Ladies, we love you very much." Politely, they approved a supplementary report of the Council endorsing the principle of accreditation and declaring that A.H.A. "will continue to cooperate with the National League for Nursing, and other interested groups, with regard to nursing service and nursing education matters."

With that approval, the debate on nursing school accreditation was closed. "That settles *that!*" said the presiding officer – Dr. Albert W. Snoke of New Haven, Conn. The ladies, who sat in the back of the room listening in, didn't say what they thought, or whom they loved, but some of them made it plain to friends afterward that they did not look upon the action of the House as an occasion for unrestrained cheering. "Nurses don't try to accredit hospitals," one of the loved but abandoned ladies pointed out.

The only other extended debate in the House had to do with association policy on financing health care of the retired aged. A statement proposed by the Council on Government Relations, repeating the belief asserted by the board of trustees last November that use of the social security mechanism may be necessary ultimately to meet

the hospital needs of the retired aged, was opposed immediately by Delegate Horace M. Cardwell of Texas, who objected that such a statement by one of its members would bind the Joint Council to Improve the Care of the Aged, which was just now starting its investigations of the problem. When it developed that this was not the case, because the Joint Council was not established to influence legislation and its members were free to take any stand they wished on legislative matters, Delegate Cardwell still objected to stating that the association believes social security may be the ultimate answer, and his objections found sympathetic support in the House. "I'm not sure we do believe it," said Dr. I. S. Geetter of Connecticut, obviously speaking for many.

After nearly an hour of what Delegate James F. Collins of Massachusetts referred to during the debate as "semantic somersaults," the House finally approved a statement including this paragraph:

"The American Hospital Association believes that every realistic effort should be made to meet the hospital needs of the retired aged promptly through mechanisms utilizing existing systems of voluntary prepayment. It is conceivable, however, that the use of social security to provide the mechanism to assist in the solution of the problem of financing these needs may be necessary ultimately."

There was one dissenting vote – cast by Delegate Cardwell of Texas.

In a press conference following adjournment of the House, newly-named President-Elect Russell A. Nelson described the action as "realistic." Any system that would permit payment of hospital bills for older, retired people on a prepayment basis would make it easier for hospitals to give care, he said, and "every encouragement and stimulation should be given to voluntary health insurance plans to do this."

Nevertheless, Dr. Nelson added: "There is every indication that there will be social security legislation for health care of the aged. The Congress is extremely impressed with this problem and will press for such legislation."

In its only other action amending or adding to a published council or committee report, the House of Delegates approved a statement by Connecticut Delegate Geetter, a member of the review committee of the Council on Professional Practice, calling attention to the "untoward effects" that may befall hospitals, and especially the smaller hospitals, due to the action of the National Intern Matching Program combining with the program of the Educational Council for Foreign Medical Graduates.

RUSSELL A. NELSON, M.D.
President-Elect of the A.H.A.

Unexpectedly poor results from the first examination of foreign graduates last March threatened some hospitals with loss of approvals, the report said, urging the A.H.A. to take steps to defer inclusion of foreign medical graduates in the Intern Matching Program and examine the present testing mechanism of the E.C.F.M.G., in view of the high percentage of failures.

Reasons for Success

Satisfied with the way the House conducted its business, and especially with the debates on nursing school accreditation and financing health care of the aged, delegates and members who looked on generally credited the results to two phenomena. These were:

1. The review committees of the various councils, which met on Sunday afternoon preceding the opening session of the House Monday morning, giving members an opportunity to discuss council reports and recommendations, with council and staff members present to answer questions, present facts and explain recommendations. "This year the review committees really worked," a staff member said, reporting that as many as 50 or 60 members showed up and took part in the review committee discussions on accreditation and social security.

2. Past President Albert W. Snoke, who presided over the House, frequently abandoning the rôle of the impartial presiding officer and jumping into the debate, but giving everybody a chance to be heard, at whatever tedious length, and maintaining an orderly, good humored spirit throughout debates that might easily have become confused or acrimonious or both.

"Snoke was great," said the delegates, obviously undisturbed by his occasional opinionated wisecracks, whose propriety might have been questioned by parliamentary purists.

Time to Think

"Everybody around here has been swooning over Chet Huntley, but I said I'd wait and swoon over Joe Welch – and I think I was right," a sprightly, if irreverent, delegate commented at the close of the Thursday morning general assembly. Probably nobody would be more surprised to know that he rates as swoon stuff than "Joe," more formally known as Joseph N. Welch, senior partner of Hale and Dorr, Boston attorneys, who looks like everybody's grandfather. But if the audience didn't swoon over the speaker's earnest plea to stop running and start thinking it certainly applauded long and loudly.

Mr. Welch's topic, "The Informed Man," was in keeping with the tenor of all the talks given at the general assemblies, which emphasized national and world trends, primarily, and hospital and health problems only secondarily. At the Tuesday afternoon assembly, Mr. Huntley, television news commentator for the National Broadcasting Company, swung wide over a variety of subjects, ranging from the necessity of doubling teachers' salaries to the position of the United States in the Middle East. On Tuesday morning, Dr. Hugh H. Hussey, professor of medicine at Georgetown University, Washington, D.C., speaking on "The Challenge Facing Health Care Today," pointed out that the greatest challenge lies in man's own mind and until the "almost universal affliction of inertia" is overcome, there is no hope for improvement.

About the only hope that Mr. Welch sees for a world which "worships a new god named Speed, whose ritual is Noise," is for the average citizen to take the time to become properly informed on what is happening all around him by reading, listening, discussing and thinking. He urged all who seek to become informed to "start at home"—that is, with a careful study of local government because it most closely affects the individual, and then move on to an analysis of state and national governments and world affairs. The three prime sources of information, Mr. Welch stated, are: (1) a *good* newspaper (specifically, the New York *Times*), (2) a dependable and intelligent newscaster, and (3) a good news magazine.

He pointed out that it is not enough to listen to a "five-minute burst of news every hour on the hour" or to glance at headlines. The news must be read or listened to in an attitude of thoughtful attention, then discussed with a questioning mind: "What does it mean?" "Does it affect us?" "Can public opinion shape events?"

Although he bowed politely to tele-

vision and radio as means of gathering information, he contended that "there is no substitute for the printed page and a little leisure, a little time to think. . . . One thing that remains constant [in a changing world] is the speed with which the human eye and mind can read and digest."

Finally, Mr. Welch warned that a civilization which is not thoughtful will die — and the end may not come slowly. "One piece of magic that is stronger than the hydrogen bomb," he concluded, "is the power of an idea. Peace will not come through machines; it will come from the minds and hearts of thoughtful and informed men."

Progressive Care

Progressive care, or the systematic classification of hospital patients according to medical needs, is either the greatest thing that has happened to patients since the Good Samaritan or a fringe experiment whose advantages are unconvincing, if not completely illusory.

The first view was presented at a conference on hospital planning by Edward J. Thoms, administrator of the Manchester Memorial Hospital, Manchester, Conn., who said the progressive care program there has resulted in improved care, happier patients, putative savings, better records, stronger hospital-doctor relations and general euphoria.

Those who could crowd into the meeting room where the conference was held — and many were turned away — heard these conclusions questioned by a near hospital neighbor of Manchester Memorial, Dr. Albert W. Snoke of New Haven, a man who had a busy week. Acknowledging that progressive care is a significant development and the experiments are worth carrying on, Dr. Snoke nevertheless was unconvinced that any real savings in cost or personnel had resulted. "There is danger that the arguments in favor of progressive care are all based on improved hospital-medical relations and patient satisfaction," he said. "The case for progressive care hasn't been proved. The implication is that as many as 40 per cent of hospital patients don't need the kind of care they have been getting. I doubt this."

Answering Dr. Snoke, Mr. Thoms pointed out that while physicians from New Haven had visited Manchester to observe the program at first hand Dr. Snoke had not, and Dr. Faye G. Abdellah, chief of the U. S. Public Health Service research group at Manchester, described some of the observations made by the research team there, having to do with medical and nursing care of patients and the doctor-nurse-patient-family relationships involved.

If the discussion about progressive care at the conference on hospital planning was inconclusive, so were the arguments about it that were carried on in corridors and hotel rooms throughout the convention, and at the progressive care exhibit presented by the Public Health Service research group. The exhibit was a rallying-ground for progressive care enthusiasts, including one who got his information the hard way — as a patient in the Special Care Unit at Manchester. This was Elmer Weden, Manchester merchant who is president of the hospital's board of trustees. "Ed Thoms has stolen the convention!" Mr. Weden said spiritedly, looking around the exhibit, which was jammed with interested visitors. According to Mr. Weden, opposition to progressive care all stems from big, teaching hospitals which haven't yet tried it.

Actually, there was little direct opposition to progressive care, but many insisted there were some questions that still remained to be answered. "There are interesting studies going on which we all want to follow," Dr. Russell A. Nelson of the Johns Hopkins Hospital, Baltimore, A.H.A. president-elect, told reporters in reply to a question on the subject. "The idea is appealing, but we need facts before we start changing our basic hospital and nursing care system."

There was no argument at all about the subjects of a couple of other conferences — hospital infections and accreditation. At the conference on infections, Dr. Alexander D. Langmuir, chief of epidemiology at the Public Health Service's Communicable Disease Center, Atlanta, Ga., attributed the sharp rise in hospital infections to "a general breakdown in respect for aseptic technics over the last 20 years," and Dr. Carl W. Walter, surgeon at Boston's Peter Bent Brigham Hospital and author of the standard textbook, "Aseptic Treatment of Wounds," startled the standing-room-only audience with slides demonstrating how a single infected patient contaminated everything she touched and seeded the air with virulent organisms.

Reporting on accreditation standards, Dr. Babcock said a proposed amendment to allow clean surgical cases to be located on obstetric floors would not be approved. "With infection rampant in hospitals and the community, this is no time to lower the bars," he said. "The staphylococcus peril is greater than any of you can imagine."

NEW OFFICERS

PRESIDENT-ELECT: Dr. Russell A. Nelson, director, Johns Hopkins Hospital, Baltimore.

TREASURER: John N. Hatfield, director, Passavant Memorial Hospital, Chicago.

BOARD OF TRUSTEES: Dr. D. R. Easton, medical superintendent, Royal Alexandra Hospital, Edmonton, Alta.; Frank S. Groner, administrator, Baptist Memorial Hospital, Memphis, Tenn., and Clarence E. Wonnacott, administrator, Dr. William H. Groves Latter-Day Saints Hospital, Salt Lake City.

DELEGATES-AT-LARGE: C. P. Cardwell Jr., director, Medical College of Virginia, Hospital Division, Richmond; Dr. J. Gilbert Turner, executive director, Royal Victoria Hospital, Montreal, Que.; Ronald D. Yaw, director, Blodgett Memorial Hospital, Grand Rapids, Mich., and Dr. Roy A. Wolford, deputy chief medical director, Veterans Administration, Washington, D.C.

TO FILL UNEXPIRED TERM: A. A. Alta, administrator, San Antonio Community Hospital, Upland, Calif.

The College

Ray E. Brown, superintendent of the University of Chicago Clinics and a past president of the American Hospital Association, was named president-elect of the American College of Hospital Administrators at the 24th annual membership assembly of the College. Mr. Brown will succeed Anthony W. Eckert, director of Perth Amboy General Hospital, Perth Amboy, N.J., who became president at the assembly. Frank S. Groner, Baptist Memorial Hospital, Memphis, Tenn., was the retiring president.

Commemorating its 25th anniversary, the College named 25 Honorary Fellows who were cited at the annual convocation. During the convocation ceremony, 112 hospital administrators were elevated to fellowship in the College, 223 nominees were admitted to membership, and 366 candidates were made nominees.

The 10th annual Arthur C. Bachmeyer Memorial Address was presented at the annual College banquet by Ordway Tead, vice president of Harper & Brothers, New York City. Talking on the art of administration, Mr. Tead listed some of the unique situations that characterize administration in the hospital setting, and make it a critical and exacting task.

The factors named by the speaker included around the clock operation, existence of a variety of specialized professional groups, conflicting interests within the organization, and the need to keep the social objectives of the institution as primary purposes of all the groups concerned. (For additional news, see page 198.)

The Modern Hospital
SEPTEMBER 1958

LOOKING AROUND

Doctors' Offices

KICKING hospitals around has become a definitive sport, like bowling on the green, and in recent years hospitals have been abused publicly for everything from inhumanity to patients to inefficiency in management. The latest exercise of this kind, happily restricted to a pamphlet that is not likely to attract wide popular readership, adds a new charge: "A dangerous tendency by hospitals to broaden out into commercial enterprises and to rent office space to physicians who are thus enabled to utilize these publicly endowed facilities for private gain."

This essay* on doctors' offices at hospitals, subtitled "A Study of Hospital Expansion Into Commercial Enterprise, and of the Effects Upon Physicians, Patients and Private Business," is a curious blend of reports from the hospital literature, legitimate questions about some current hospital practices, and editorializing by the authors, who remain unidentified. A three-page summary at the beginning of the pamphlet is signed by M. C. Vieth, executive director of the Foundation for Management Research, which is said to be supported by 4000 industry members, but Mr. Vieth denies authorship of the text, which includes several references to "the authors of this report."

Whoever they are, the authors make it plain that they are opposed to doctors' offices at hospitals. Their principal concern, obviously, is that physicians are permitted to use such offices for their own private gain, that such "profits" to physicians may jeopardize the tax-exempt status of the hospital, and that such jeopardy to the hospital in turn may raise a question about the tax-deductibility of corporate contributions to nonprofit hospitals. These are all reasonable concerns that have been studied by thoughtful hospital people, who have also considered the same questions in connection with the physician's use of hospital facilities generally in private practice. The authors of this report never do explain why they consider it sinful, if not criminal, for the hospital to furnish consulting rooms for physicians to use in their private practice but perfectly acceptable to furnish operating rooms, laboratories, and other facilities for the same purpose.

Other legitimate questions raised in this frequently entertaining though not always grammatical pamphlet have to do with the wisdom and propriety of furnishing offices for some physicians but excluding others, and with the costs of operating medical office buildings, compared to the revenues and other benefits derived therefrom.

Unquestionably, the authors have made a diligent search of the literature on doctors' offices at hospitals; the report is abundantly footnoted and powdered with scholarly *ibids* and *op cits*. When they abandon the literature and make statements on their own authority, however, they are frequently wide of the mark. Thus for example they say, "It is currently reported that the hospital plans to build another annex to provide space for another 100 physicians," referring to a new building that has *already been completed* at the Baptist Memorial Hospital of Memphis, Tenn. At another point in the text, it is reported that "most hospitals" do not include depreciation of assets and interest on invested capital in figuring expense — an assertion that might have been true a few years ago but is certainly open to question today. Again, the authors state that "hospital office buildings have taken to operating restaurants, barber shops, haberdasheries, commercial drugstores and surgical supply shops," but they name only a single institution where such enterprises have been undertaken. Similarly, they insist that "in many instances" hospital offices have been used as the basis for building profitable, private, group practice clinics, yet only one or two such instances are actually named, and the term "group practice clinic" is applied impartially to every variety of office-hospital arrangement. The informed reader may also wonder how much and what kind of research was required to produce the flat statement that "medical office buildings today cost at least $6.46 per square foot to amortize and operate" and the unsupported assertion that "an air conditioned medical office building is much more expensive to build than a hospital."

The dim view of physicians' offices at hospitals becomes positively dark, however, when the authors begin to question the motives of physicians, hospital administrators and trustees who are engaged in what they plainly regard as devious plotting to thwart the ends of honest businessmen. "The principles of otherwise high-minded hospital trustees begin to quiver and fade when the emoluments of staff membership become so high and

*Doctors' Offices in Hospital-Financed Buildings, a Study of Hospital Expansion Into Commercial Enterprise, and of the Effects Upon Physicians, Patients and Private Business. Published by The Foundation for Management Research, Inc., 121 West Adams Street, Chicago, Ill. Paper. Pp. 40.

there is a bright, up-and-coming son, nephew or relative-in-law of an important business associate who can displace a staff member, and does," they say in one foreboding, though somewhat obscure, passage.

Hints and threats also peep out from the discussion of tax exemption. "The federal government is beginning to take a bilious view of the situation," says the text, not explaining what this means. Discussing use of tax-free hospital parking lots by private physicians and their patients, the authors suggest that "a challenge of this situation by some irate property owner might raise hob with a hospital's property tax situation."

It seems unlikely there is going to be any hob left for irate property owners to raise when the authors are through. "The presence of physicians' offices in or adjacent to hospitals, or presence of hospital-run commercial enterprises, may almost be taken as a sign that the hospital trustees have resigned their responsibilities and decided not to grapple realistically with the problems of hospital bed space, or use of x-ray and laboratory by outpatients," they say in a final burst of free-style malediction. "Instead of seeking the basic reasons for such non-use of facilities (if non-use exists), the trustees have fallen back on the solution of subsidizing physicians to send patients to the given hospital, which is like a manufacturer bribing retail dealers with an extra large discount to push an inferior piece of merchandise which couldn't sell on its own merits."

Well! There must be a reason for so much contumely, but the reason is never made clear. In reply to a question, Mr. Vieth said the study was requested by industry members of the Foundation seeking information on which to base corporate donations to hospitals, and that copies of the pamphlet would be distributed to members. The service to Foundation members in this case has been supplemented by a press release summarizing the findings and opinions set forth in the pamphlet. The press release was issued by "Imberman and DeForest, Public Relations." Asked who Imberman and DeForest were, Mr. Vieth said, "They do the public relations for our projects."

For "they" he might have said "we." As it turns out, the Foundation for Management Research, Inc., at 121 West Adams Street, Chicago, shares an office with Imberman and DeForest, whose address is given on the press release – somewhat disingenuously, it seemed to us – as 209 South LaSalle Street, an around-the-corner address to the same office building.

Guests

DON'T look now, but there may be an unwelcome guest in your hospital, one whose presence there would shock the patients and visitors even more than it has upset them to discover in recent months that they have been sharing the premises with *Staphylococcus aureus*. Unlike *Staph.*, this bug rarely invades the operating room or the nursery – though he may be seen on occasion in both places, especially in old buildings with lazy housekeepers.

In one hospital not long ago, for example, an observer found *Blatta orientalis* enjoying the warm, moist atmosphere of an incubator, which was also occupied at the time, unfortunately, by a premature infant. "We could not treat this instrument with insecticide, because the baby in it was too delicate," said Professor Hubert Frings of the department of zoology and entomology of Pennsylvania State University.*

Professor Frings found *Blatta orientalis*, or cockroaches, all over in the hospital he visited, which he mercifully failed to identify. As a matter of fact, he observed, the vermin were especially numerous in the nursery, where they had established headquarters behind some loosely fastened trim around a doorway. "That decorative woodwork could just as well have been omitted," he pointed out. "Yet there it was, harboring pests whose very presence was unthinkable. In a new wing of the hospital, where wood frames had been omitted and the doorways were finished smooth, we found far fewer roaches. They just did not have places to hide."

When he also found *Blatta* in the operating rooms, wards and nurses' quarters, Professor Frings began to wonder how they were getting around. Eventually, he found the answer – in the hospital laundry. Soiled linen was collected, and clean linen distributed, in wicker baskets reinforced with loosely fitted wood strips – neatly designed to provide crevices where pests could hide. "We asked to inspect one of the trucks, but the orderly said it was loaded with uniforms for an operation and he had to get them to the operating room immediately," the professor reported. "When he returned in a few minutes, we blasted thousands of roaches out of that truck."

It should be possible, Professor Frings suggested, to design hospitals, and hospital equipment, and hospital furnishings, to eliminate or greatly diminish the number of what he referred to as "roach roosts." Meanwhile, hospital buildings should be examined by experts who can find the places *Blatta* is hiding, and the routes it is riding, and show hospital executives the way to get rid of this embarrassing, and dangerous, beast.

*Frings, Hubert: Why Not Pest-Prevention Construction. Progressive Architecture, 39:136 (May) 1958.

Hear! Hear!

SEEKING to put the wholesome American pastime of panning the boss on a scientific footing, sociologists at Michigan State University recently queried a group of dietitians about the way their administrators act in conferences, and especially about their listening habits. The results, as summarized in an article in the *Journal of the American Dietetic Association*, probably represent the most elaborate method ever devised for saying, "The Old Man is a stinker!" Asked to choose the ones that bothered them most from a list of 60 administrative antics, ranging all the way from "He has such a poker face that I never know whether he's listening" to "He says he has to go to another meeting," the dietitians decided the following were the most frequent and most irritating habits:

1. He passes the buck on problems.
2. He asks questions as if he doubted everything I say.
3. He gives me the feeling that I'm wasting his time.
4. Whenever I make a suggestion, he always throws cold water on it.
5. He fails to get down to the basis of the argument.

In a spirit of helpfulness to dietitians, we are glad to offer herewith our own remedies to the problems they found so vexing, in the same order:

1. Where to? Why not find out and take it there yourself?
2. Let him ask the questions first, before you say anything.
3. Well?
4. Wait till he makes a suggestion!
5. What do you mean, down?

How to make your statistics work for you

Robert G. Hoffmann

CONTRARY to what most people think, statistics are not just dull, dry figures that have no interest for anyone except dull, dry statisticians. Far from being dull and dry, statistics generally involve lively discussions and, in many cases, have great significance for hospital administrators.

As a concrete example of the value to hospitals of sound statistics soundly applied, let us consider a hypothetical situation that has arisen in Mythical Hospital – which could easily be your own.

The board of trustees is meeting and Mr. Blunt, chairman of the board, speaks: "I have just read an article in the *American Journal of Something-or-Other* which says that Blue Cross patients are staying in the hospital longer than private patients and, Mr. Holdenbag, as director of this hospital, I want you to do something about it."

Although this is a hypothetical example, many studies or problems actually start in somewhat the same way. If you were Mr. Holdenbag, hospital administrator, what would you do? Let's examine some possibilities.

(*Continued on Next Page*)

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Routine Statistical Reports and What They Ought to Include

How simple or how complex a hospital's routine statistical reports are depends upon its own interests and needs. Hospital problems may be considered in two categories: (a) recurrent or continuing problems and (b) special problems.

For recurrent or continuing problems, continuous information needs to be available. As a simple example, you always need to know whether the hospital is making or losing money, and one factor that is related to the financial picture is average occupancy. Hence, financial data and occupancy rates fall into the recurrent or continuing problem category. As an example of a special problem, you might want to know whether or not it is worth while for the hospital pharmacy to stock a given drug—or to have a pharmacy at all, for that matter. For such problems, special information must be gathered and studied until a decision can be reached. Most problems in medical statistics are sufficiently complex so that it is not worth while to set up routine reports for them. In other words, specific topics should be studied on a special basis.

What all the foregoing indicates is that routine statistical reports should consist of (a) information gathered for recurrent or continuing problems and (b) information gathered for a special problem—and it is up to you to decide when a problem is special. All reports of any kind are largely dependent on records, both financial and medical. The ease with which you can prepare reports depends on the accessibility of information, so some worth-while special studies might be made of your own record systems.

I have attempted in this article to provide a glimpse of a few problems similar to those with which hospital administrators are faced, and to show how some of them are approached by statisticians. Those who master the elements of statistical reasoning acquire a depth of vision that they previously did not have. The lack of this vision was eloquently lamented many years ago by Charles Darwin, who said—"I have deeply regretted that I did not proceed far enough at least to understand something of the great leading principles of mathematics, for men thus endowed seem to have an extra sense."

THE PROBLEM OF LENGTH OF HOSPITAL STAY INVOLVES MANY FACTORS

(*Continued From Page 69*)

You might go home and glumly telephone your chief of staff and arrange for an authoritative letter to be written and signed by the chiefs of services stating that Blue Cross patients were *not* staying longer than private patients. If the trustees accepted the letter, then all would be harmonious, but the question that was asked and the answer given would provide little information as to length of stay of Blue Cross and private patients in the hospital. Why? Because neither the board nor the staff physicians had any factual information about length of stay. It would be one set of opinions *versus* another set of opinions.

But let us suppose that you decide to arm yourself with some facts and figures. You instruct your librarian to compute the average length of hospital stay for the two groups for the past year. She not only does this but proudly presents a "statistical chart" which portrays these averages (Fig. 1).

"This," you crow delightedly, "ought to get old Blunt off my back. Our private patients are staying three days longer than our Blue Cross patients."

You might be a bit disturbed at how much longer the private patients are staying (is this reasonable?) but no one can dispute the figures. The librarian double-checked them so these are the facts. Does this answer the question? No. Not at all. Before going into why it doesn't, let's take another look at the question.

Mr. Blunt quoted an article which said that Blue Cross patients stayed in the hospital longer than private patients. By saying what he did, he assumed (without saying so) a number of things:

1. That the study results in the article were valid or, in other words, accurately reflected the real-life situation.
2. That a similar situation applied in his hospital.
3. That everyone "knew what he really meant."

The answer to Mr. Blunt's question as he actually phrased it is both Yes and No because *some* Blue Cross patients stay longer than *some* private patients in any hospital and the reverse is equally true. What Mr. Blunt meant was something like this: "If a patient comes into our hospital, is he likely to stay longer if he has Blue Cross than he would if he paid his bill directly?" This question implies that to make a valid comparison of payment groups, the patients should be similar in most respects except in the matter of who pays the bill. In other words, the patients studied should all be 70-year-old women with fractured hips, for example, some of whom pay through Blue Cross and some who pay directly.

This is what is wrong with the chart which indicates that the Blue Cross patients were staying, on the average, three days less than the private patients were. The Blue Cross patients could be mostly children with relatively minor complaints while the private patients could be mostly older patients with serious illnesses requiring long hospitalization. This is why Mr. Holdenbag's chart, at best, could only add to the confusion.

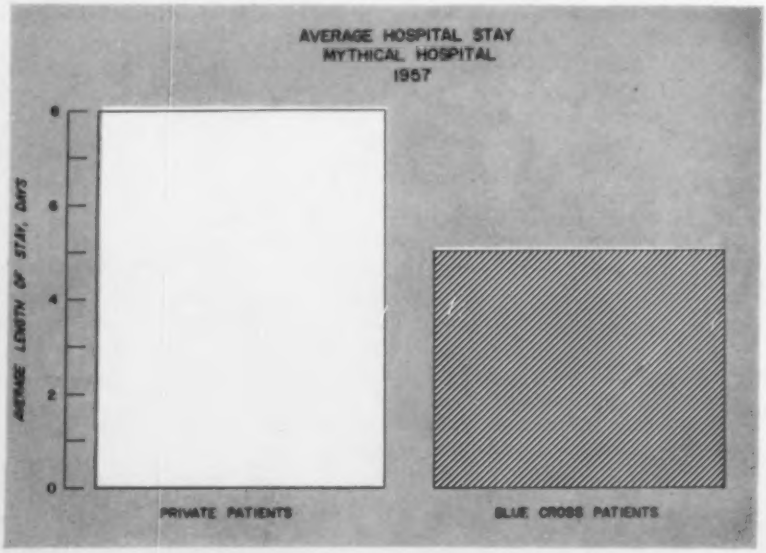
The real problem of appropriate length of hospital stay is a complex one and involves many factors, including the hospital facilities available, home facilities of the patient, patterns of medical practices in the hospital, and, possibly, who might be paying the bill. Then, too, the final decision about length of stay is usually made by the attending physician, so if one physician keeps his Blue Cross patients a little longer than other physicians keep their private patients with comparable conditions, this does not mean that all physicians do the same, even in the same hospital.

Mr. Blunt's and Mr. Holdenbag's troubles were encountered only because they did not clearly agree on a workable problem in the first place, and this matter of setting up a workable problem is of prime importance to the accomplishment of anything worth while. What is a workable problem? This is no trivial question, because a problem not only implies some kind of solution but a reason for being set up in the first place. What was Mr. Blunt's purpose in bringing up length of hospitalization and what was Mr. Holdenbag's purpose in answering the question? Many purposes could be hypothesized but this is getting a little far afield of our main discussion of statistics. Purposes, however, should never be ignored.

For our purposes we shall say that a workable problem has these characteristics:

1. Everyone knows what the problem is.

Fig. 1.: Because it was wrongly conceived, this "statistical chart" showing average lengths of stay by private and Blue Cross patients has no validity.



AN UNEQUIVOCAL MEASUREMENT IS WORTH THE TIME SPENT SEEKING IT

2. Some unequivocal measurements can be made which are relevant to the problem.

3. When the data (measurements) have been examined, everyone will agree generally as to the conclusions that have been reached.

Most problems which involve complex definitions as a starting point are not workable problems. Two classic examples in the hospital field are the categories of major and minor surgery, and the classification of patients into "recovered," "improved," and so on. Although much has been written condemning these two categories, the same criticisms apply to any problems that involve a complex definition. Consider another example (factual this time) which involved a not-so-complicated definition.

At a meeting of medical record librarians, each librarian was asked how she would answer a questionnaire that asked for the number of sterilizations which had been done in the hospital.

Fig. 2: This table showing number of appendectomies could be used to compute several relationships, so it is essential to know which is wanted.

Hypothetical Appendectomy Data

Patients With:	Male	Female	Total
Acute appendicitis	75	25	100
Other appendicitis	60	40	100
Total	135	65	200

Some would have included hysterectomies; others would not have counted them. How could the results be interpreted without any information as to what was being included in the sterilizations? In this case everyone did not agree on what was a sterilization and until they discussed the matter, they were not aware of their own disagreement. If the questionnaire had asked for the number of (a) bilateral oophorectomies, (b) bilateral tubal excisions or ligations, and (c) hysterectomies, the data obtained would probably have been sound. A paragraph explaining that the number of sterilizations was wanted would help in counting some surgery which otherwise might be missed, *e.g.* a second oophorectomy after the first had been done. With this approach, anyone who can recognize the names of surgical operations would arrive at the same number of "sterilizations" in a given hospital and no definition of sterilization is necessary.

Definitions, then, should be used only when an unequivocal measurement cannot be found, and time spent in looking for unequivocal measurements will always be worth while. If a complicated definition is used as a starting point, you can be fairly certain that you will not be able to interpret your data very well.

So far we have discussed "workable problems" and have shown how people can become confused (sometimes without knowing it) without some unequivocal measurements. Let's take a closer look at "unequivocal measurements."

We have already given one example — counting bilateral oophorectomies and so on. This is unequivocal because hospital records are written (assuming they are accurate) and anyone who knows how to count them will arrive at the same answer. Another example would be the size of Mr. Jones' hospital bill. Anyone can look in the records and see that Mr. Jones' bill was $1,572.31.

We might say that an unequivocal measurement is one that is relatively independent of the person taking the measurement. Written records which can be abstracted directly are excellent sources of unequivocal measurements but don't overlook the fact that these sources may not accurately reflect the real-life situation of which they are records. For example, a patient may give his age as 45 when in fact he is 47 years old. At least everyone taking the patient's age from the record will take 45 years and thus have a common, though slightly erroneous, starting point. Sometimes these errors can be detected in a body of data.

We have emphasized unequivocal measurements or factual data as a starting point. Let's see how these measurements can be used as well as misused by another example.

Not long ago we prepared a report for a number of hospitals which compared the hemoglobin determinations being done in the hospital laboratories and one hospital had a low average. We were approached by the hospital administrator who worriedly asked us if his laboratory was operating properly and said that, in the opinion of his staff physicians, the low average of hemoglobins was just due to the patients being treated. Were the physicians right, the worried administrator wanted to know.

We had to point out that no one's opinion was of value in this kind of problem. The only way of determining whether his laboratory was operating properly was to run some standard tests in the laboratory itself and, unknown to the administrator, the laboratory technician had been testing standards. The technician's tests indicated that the laboratory was not operating properly and was producing low hemoglobin results. Incidentally, we examined this hospital's hemoglobin data a year and a half later and they were still low. Apparently they like erroneously low hemoglobin tests.

At this point the reader might be thinking "What I have read so far is well and good, but I get a statistical report for my hospital each month and nothing has been said about it so far." These reports have been discussed indirectly under the heading of "workable problems." You at least will want to know how many patients were admitted and discharged during the month, how many empty beds you had, where they were, what was wrong with the patients, and so on. How simple or complex your report is

depends upon your own needs and interests. There is no neat set of rules to tell what should be included in a statistical report. You must analyze your own problems, discuss them with your staff and board of trustees, and constantly ask yourself, "Are there better ways to do what I am doing? Are we getting the information we need and discarding information that we do not need?" If you get stuck, remember that consultants are available to help you over the rough spots. A little more will be said about monthly reports later on.

Let's get back to our discussion of problems and at this point assume that we have a workable problem and that our problem involves *counting* things. We will assume that we are going to count the patients who had appendicitis and prepare a small table as shown in Figure 2 on page 71.

The numbers as they appear in Figure 2 are not too easy to use directly, so what are often computed are per cents. But before you rush off to the calculator to compute the per cent, you must decide what you want to know because there are several kinds of per cent that can be computed solely from the data in this little table. Let's look at a few.

Who Has Appendicitis?

Let's forget about the women (only for a moment) and ask ourselves: "Do males usually have acute appendicitis more than other types of appendicitis?" Information is to be found in the column headed "Male" and we compute 75/135 x 100 = 56%. The answer to our question is: "I don't know. Of the males in our sample, slightly more than half (56%) had acute appendicitis, but we are not sure this is so." We will consider this problem of the generality and certainty of our results later.

Now let's consider a similar question for the women and compute 25/65 x 100 = 38%. We are now in a position to make a sex comparison thus:

Per cent with acute appendicitis: male – 56%; female – 38%.

So it appears in our hypothetical data that males have acute appendicitis more often than do females. In the foregoing examples we considered each sex separately and then compared the two sexes. Now let's look at our appendicitis data from another point of view. This time we will look at the group of patients who have acute appendicitis and ask, "Of the patients who have acute appendicitis, what per cent are males?" We compute 75/100 x 100 = 75%. Similarly for the patients with other types of appendicitis we can compute 60/100 x 100 = 60% and are then in a position to make a comparison of the two classes of appendicitis. Other percentages based on the total number of patients could be computed and would be useful for different purposes.

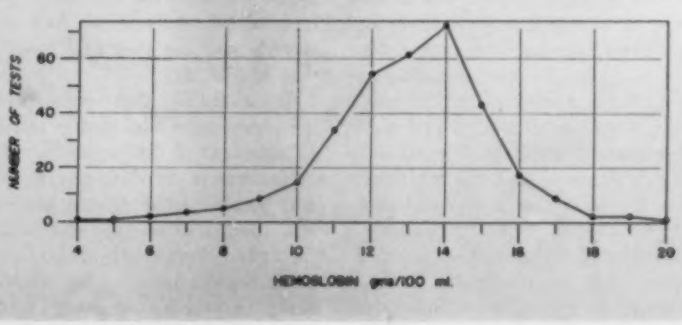
Please note that in presenting a percentage by itself, you lose sight of the number of things that went into the computations and this is important. Would you have the same faith in a 50 per cent figure that was based on two observations as you would in a 50 per cent that was based on 500 observations? Other things being equal, the 50 per cent based on the 500 observations would be a much

Fig. 3: To determine how the laboratory is reporting on hemoglobins statisticians construct frequency distribution, based on tally sheet below.

Fig. 4: This chart (at bottom of page) summarizes the data shown on tally sheet in terms of hemoglobin gms/100 ml., but in order to have numbers that can be used to compare with other distributions, it will be necessary to compute arithmetic mean and standard deviation.

Hypothetical Hemoglobin Data

Hemoglobin Value gms./100 ml.	Tally	Total
3		
4	I	1
5	I	1
6	II	2
7	III	3
8	𝍸	5
9	𝍸 III	8
10	𝍸 𝍸 IIII	14
11	𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 III	33
12	𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 IIII	54
13	𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 I	61
14	𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 II	72
15	𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 𝍸 III	43
16	𝍸 𝍸 𝍸 III	18
17	𝍸 IIII	9
18	II	2
19	II	2
20	I	1
		329



more stable estimate, so, if you compute percentages, you should also show the number which was used as a base for your per cent.

Before we leave counts of things and per cents, we should consider one further aspect of "workable problems."

The question is something like this: "What do we wish to say about our data?" This question should be considered before you start collecting data – routine or special.

Let's look at the appendectomy data with regard to some questions. We could ask: "When male patients throughout the United States have appendicitis, what per cent of them have acute appendicitis?" This is no simple question and in order to estimate acute appendicitis for the entire United States you need a sample that represents the whole country. Problems of this kind are considered under the general heading of statistical sampling theory and we will not discuss them here. You should know, however, that you do not need data concerning all patients in order to find out about the United States as a whole, but on the other hand you cannot use data only from your own, or a few local hospitals, to represent the entire country.[1]

Compare With Past Data

Let's look at the appendectomy data from the particular point of view of a hospital administrator. You may ask: "Is the picture of appendicitis changing in our hospital as the years go by?" In this case you will want to regard your data as samples in *time* and will make comparisons of current data with past data.

Before going on to the next discussion of problems, let's review a little. We have been discussing "workable problems" which we have agreed are those that can be stated in advance so that everyone will know what the problem is; that some unequivocal measurements can be made which are relevant to the problem, and that, when the data have been examined, everyone will agree as to the conclusions reached.

We have looked at some hypothetical appendicitis data as a means of illustrating some of the ways of handling data which involve counts of things. Remember that we could not be certain that (hypothetically) more males than females have acute appendicitis. The point here is that our "workable problem" rules are a set of ideal rules which can only be used as guides. "Perfect" solutions to most problems are few and far between.

Let's try another problem. We will assume that you want to investigate the accuracy of the hemoglobin tests in your own hospital laboratory. We now have a different kind of problem because a count of the number of tests done tells nothing about how accurately they have been done.

What Are the Values?

Suppose you call in your pathologist, Dr. Testit, and tell him you would like to know how well the hemoglobins are doing. He replies that he is not getting many complaints from the staff so they are all right. If you accept this we don't have a problem to talk about, so we will assume that you decide to look at some of the hemoglobin test values. Dr. Testit marches down to the laboratory and returns with a handful (several hundred) of hemoglobin reports. Our problem at the moment is how to summarize these several hundred hemoglobin reports so we can get a picture of how the laboratory is reporting. We do this by constructing in the following fashion what statisticians call a frequency distribution. First prepare a tally sheet that looks like Figure 3. Then, to get a picture of what our hemoglobins look like, we prepare the chart shown in Figure 4.

Do we now, by studying the hemoglobin distribution, know how well the hemoglobins are going? Partly. We know, for example, that values around 14 gms. are most frequently reported by the laboratory (assuming that our sample of 329 tests represents the usual work of the laboratory).

Dr. Testit may examine our distributions and say: "This is just exactly what a well run laboratory should be expected to produce." But how would he know? For that matter how does anyone know whether "something is going as it should?" To consider for a moment another familiar example, how do you know how well your hospital is doing financially? I imagine that you keep track by studying your financial statements. In other words, you *compare* your assets and liabilities to see how things are going.

If Dr. Testit said the hemoglobins were all right after examining the distribution, he would be comparing his impression of what hemoglobin distributions should look like with the distribution you tabulated. Unlike the balance sheet, however, you have no hemoglobin "assets and liabilities"; you have only a distribution. How, then, are we to summarize this distribution so that we will have some numbers that we can use to compare with other hemoglobin distributions? We do this by computing certain things which statisticians call estimates of population parameters. The parameters most often computed for distributions like our hemoglobin are the arithmetic mean and standard deviation. We will not go into the computation and meaning of these parameters here. With them, however, you will have some numbers to compare with other hemoglobin distributions, if you can find other data.

Recommended Reading

Perhaps there are some readers whose statistical appetites have been whetted enough so that they are really interested in learning something about the field. For these readers, there is a book which can wholeheartedly be recommended.[2] In it you will find many examples of the uses and abuses of statistical methods as well as computing technics which provide the tools for statisticians. Happily, too, in this book the technical aspects[3] (given on an elementary level) are separated from the "problem aspects" of statistics. As a result, the book can be used for casual and very enjoyable reading as well as for serious study. ■

[1] For some interesting findings as well as an outline of some sampling methods done on a national basis, read some of the reports from the U.S. National Health Survey, U.S. Department of Health, Education and Welfare, Washington, D.C.

[2] Wallis and Roberts: Statistics, A New Approach, Glencoe, Ill.: The Free Press, 1956.

[3] The technical aspects of much of statistical theory involve fairly advanced mathematics. To study it seriously you should be familiar at least with mathematics through a year of differential and integral calculus.

The Tissue Committee Really Gets Results

A five-year study of the activities and accomplishments of a tissue committee proves that it does the job it was set up to do and that its most important function has been that of educator of the staff members rather than policeman

Dominic J. Verda, M.D., and William R. Platt, M.D.

ALTHOUGH the tissue committee has been widely acclaimed for its effectiveness in improving the quality of surgery in hospitals, there have been few published reports conclusively demonstrating its established value.

This presentation of a five-year study of selected surgical procedures done at the Missouri Baptist Hospital, St. Louis, before and after the establishment of the tissue committee provides such proof. The survey includes a two-year period (1952-53) before the tissue committee was formed and a three-year period (1954-56) following its establishment. Five categories of operations (appendectomy, uterine suspensions, lysis of adhesions, hysterectomy and biliary surgery) were selected for this comparative study.

Dr. Verda was chairman of the tissue committee at Missouri Baptist Hospital, St. Louis, in 1956 and 1957. Dr. Platt is the hospital's pathologist and a member of the tissue committee. Dr. Verda is a fellow of the American College of Surgeons, and Dr. Platt is a fellow of the College of American Pathologists.

The most dramatic illustration of the impact of the tissue committee in the improvement of the quality of surgery is found in our five-year study of appendectomies (Table 1). This study presents a comparison of the surgeons' clinical diagnoses with the pathologists' tissue diagnoses for the pretissue and post-tissue committee period. From this table these facts are readily apparent:

1. There was a 60 per cent decrease in the number of appendectomies done following the inception of the tissue committee, while the surgical admission rate remained almost constant during the five-year period.

2. This decrease was due largely to a rapid and progressive diminution in three categories of patients: the "chronic recurrent appendicitis group," those patients with normal appendixes by pathologists' examination, and the subsiding or "subacute" category.

3. The diagnosis "chronic recurrent appendicitis" was abandoned by the pathologist after the establishment of the tissue committee.

4. There was a progressive increase in the accuracy of the surgeons' clinical diagnoses of acute appendicitis.

5. Fear of criticism by the tissue committee did not cause a significant percentage increase in gangrenous or ruptured appendixes, caused by delay in surgical treatment.

Nowhere else is the beneficial effect

Drop in number of operations for "chronic recurrent appendicitis" shows clearly the effect of the tissue committee.

TABLE 1 — APPENDECTOMY

Year	1952		1953		1954		1955		1956	
Surgical Admission Rate/Year	14,600		12,498		12,172		12,822		12,900	
Diagnosis by	Surgeons	Pathologists	Surg.	Path.	Surg.	Path.	Surg.	Path.	Surg.	Path.
Acute	231	162	178	150	92	90	106	109	98	118
Gangrenous or Ruptured	50	42	46	42	30	27	28	18	35	23
Subsiding and "Subacute"	77	63	57	28	24	18	26	11	10	7
Chronic Recurrent	156	76	79	33	34	0	25	0	13	0
Carcinoid	2	2	1	1	0	0	1	0	1	0
Normal	77	248	61	168	35	80	20	68	27	36
TOTAL	593		422		215		206		184	
Pre-Tissue Committee:	1015									
Post-Tissue Committee: ..							605			

of the tissue committee so clearly demonstrated as in the decrease of appendectomies done for such dubious clinical and pathological indications as "chronic recurrent appendicitis." In this category alone there was a progressive decrease of appendectomies done per year as follows: 1952, 26 per cent; 1953, 19 per cent; 1954, 11 per cent; 1955, 12 per cent; 1956, 7 per cent. This was accomplished through the educational activities of the tissue committee which stimulated more careful preoperative screening of patients and more accurate and thoughtful preoperative diagnoses. Concomitantly, there was a marked decrease in the number of patients whose appendixes were normal on examination by the pathologist: 1952, 42 per cent; 1953, 40 per cent; 1954, 37 per cent; 1955, 33 per cent; 1956, 20 per cent.

But at the same time there has been no significant and stable percentage rise in the rate of gangrenous or ruptured appendixes as a result of surgical delay caused by fear of possible criticism by the tissue committee. The percentages of gangrenous or ruptured appendixes by year have been: 1952, 7.1 per cent; 1953, 9.9 per cent; 1954, 12.6 per cent; 1955, 8.7 per cent; 1956, 12.5 per cent. There has been a decrease in mortality from acute appendicitis following inception of the tissue committee: one death in this three-year period as contrasted to three deaths in the two-year period before its establishment. The tissue committee has stressed constantly the philosophy that the physicians' evaluation of the clinical indications for surgery in each case determine the necessity for surgery; the removal of normal tissue does not automatically brand an operation as unjustified.

Table 2 shows the effect of the tissue committee in decreasing the incidence of surgical procedures of doubtful therapeutic value. In this study are included uterine suspension and lysis of adhesions, and it is apparent that:

1. The incidence of uterine suspension fell from 0.7 per cent of all surgical admissions in 1952 to 0.09 per cent in 1956.

2. The incidence of operation for lysis of adhesions dropped from 0.63 per cent in 1952 to 0.22 per cent in 1956.

The decreases in these two surgical procedures were a result of a marked change in medical philosophy concerning their value in relieving patients' symptoms. This resulted from the ed-

TABLE 2 — CLINICAL INDICATIONS

Year	1952	1953	1954	1955	1956
Surgery Admission Rate/Year	14,600	12,498	12,172	12,822	12,900
Retrodisplacement	57	51	25	15	9
P.I.D.	6	8	7	0	0
Uterine Prolapse	12	6	2	0	1
Exploratory Laparotomy	23	22	6	4	1
TOTAL	98	87	40	19	11
	↓ 185 Pre-Tissue Committee		↓ 70 Post-Tissue Committee		

LYSIS OF ADHESIONS

CLINICAL INDICATIONS

Simple Adhesions	21	42	17	3	7
Pericolic	18	16	6	0	2
Bowel Obstruction	12	16	8	6	8
Exploratory Laparotomy	41	29	5	16	12
TOTAL	92	103	36	25	29
	↓ 195 Pre-Tissue Committee		↓ 90 Post-Tissue Committee		

TABLE 3 — HYSTERECTOMY

Year	1952	1953	1954	1955	1956
Surgery Admission Rate/Year	14,600	12,498	12,172	12,822	12,900
Pathologists' Diagnoses					
Fibroids	128	86	68	64	76
Hyperplasia	12	9	8	14	9
Adenomyosis	13	14	7	8	12
Endometrial polyp	4	0	5	3	2
Cervicitis	22	18	12	3	4
Cancer of cervix	4	3	1	4	2
Cancer of body	4	6	7	10	7
Atrophic endometrium	0	0	0	0	2
Pregnancy	2	1	0	0	0
Post-menopausal	0	0	0	1	2
Endometriosis	33	28	10	14	20
Endometritis (functional bleeding)	34	20	7	0	1
Cervical polyp	0	0	0	0	1
Subinvolution	0	0	7	0	0
Sarcoma	0	0	0	1	0
Normal — includes uterine procidentia	15	36	12	19	11
TOTAL	271	221	154	141	149
	↓ 492 Pre-Tissue Committee		↓ 444 Post-Tissue Committee		

Table 2 indicates decrease in surgical procedures found to be of doubtful therapeutic value, authors say. Operations for uterine suspension and lysis of adhesions dropped sharply. Table 3 shows fewer hysterectomies done since tissue committee was established at Missouri Baptist.

TABLE 4 — BILIARY SURGERY

Year	1952	1953	1954	1955	1956
Surgery Admission Rate/Year	14,600	12,498	12,172	12,822	12,900
Diagnoses					
Cholecystectomy	173	153	97	123	117
Cholecystostomy	8	2	4	0	2
Common duct explored	16	12	34	30	38
Operative cholangiogram	0	4	22	16	20

Tissue committee aids in adoption of new surgical technics for biliary surgery, diminishing chances of secondary operations being necessary.

ucational activities of the tissue committee, which sponsored open staff discussions that brought about the recognition of more exact indications for such surgical procedures. Whereas in the years 1952 and 1953, 45 patients underwent uterine suspension because the uterus was found to be tilted when the surgeons were doing exploratory laparotomies for some other condition, in 1956 only one was so treated. Moreover, the incidence of uterine suspension in the treatment of retrodisplacement dropped more than 500 per cent in 1956 as compared with 1952.

The same improvement is noted in the operation of lysis of adhesions. Following inception of the tissue committee there have been more careful evaluation of patients for operation and more stringent indications for surgery; in two categories alone, "release of simple peritoneal adhesions" and "exploratory laparotomy for lysis of adhesions," there were 133 patients operated upon in the two years before the tissue committee as compared with 60 patients in the three-year period following its inception.

Table 3 presents a five-year study of the pathologists' diagnoses of uteri removed. From this it is apparent that:

1. There has been a significant decrease in the number of hysterectomies done since the establishment of the tissue committee.

2. This decrease is due largely to a drop in the number of hysterectomies done for fibroids, cervicitis, and "endometritis" (a diagnosis formerly used in cases of functional bleeding).

The indications for hysterectomy have been reviewed since the inception of the tissue committee, and operations for solitary and minute uterine fibroids, for cervicitis, and for functional uterine bleeding have diminished.

Table 4, "biliary surgery," is a prime illustration of the impact of the tissue committee in increasing the adoption of new surgical technics and procedures which are of benefit to the patient. From this table it can be seen that:

1. There was an increase of common duct exploration from 9 per cent in 1952 to 32 per cent in 1956.

2. Operative cholongiograms increased from 0 per cent in 1952 to 17 per cent in 1956.

The use of both these technics increases the possibility of discovering at the original operation common duct stones which have been overlooked and, thus, diminishes the chances of secondary operations.

Has Had Positive Influence

These are gratifying examples of the positive influence of the tissue committee upon the professional activities of the medical staff. The tissue committee should be more than a negative, or inhibiting, influence and should not be content solely with seeking the abolishment of outmoded or discredited surgical technics and procedures. It should also strive for the adoption of better methods of treating patients and of curing disease. It can best attain both of these objectives by a program of continuing education.

At the Missouri Baptist Hospital the tissue committee has fostered panel discussions upon various debatable surgical procedures; it has sponsored guest speakers to discuss new advances in surgery; it has conducted seminars for the instruction of interns and residents. From such educational activities have come a reduction in the number of unnecessary surgical procedures and an adoption of new surgical technics; patients are more carefully screened for operation, and their diagnostic workups are more thorough; the medical records are more nearly complete and of better quality; the use of consultation has increased. All of these have resulted, directly or indirectly, from the activities of the tissue committee and have elevated the quality of care of the surgical patient in the Missouri Baptist Hospital. ■

Survey Shows 51 Per Cent of Operations Performed by Certified or A. C. S. Surgeons

CHICAGO. — A study of 338 hospitalized surgical procedures representing a nationwide sample of American families indicated that 51 per cent of the operations were performed by surgeons who were certified or held fellowships in the American College of Surgeons, it was reported here last month.

In a report appearing in the September issue of the *Bulletin* of the American College of Surgeons, Odin W. Anderson, research director of the Health Information Foundation, New York, and Jacob J. Feldman, senior study director of the National Opinion Research Center, Chicago, analyzed the 338 operations reported in a survey of personal health services conducted in 1953. In the study, hospitalized surgical procedures were defined as "any cutting procedure (except cesarean delivery) or setting of a dislocation or fracture performed after the individual had been admitted to the hospital."

In addition to the 51 per cent of operations performed by certified surgeons or fellows of the College, it was reported, an additional 27 per cent were performed by doctors who said their practice was limited or special attention was given to a specialty involving surgery, although they were not certified or did not belong to the College.

The remaining 22 per cent of operations were performed by doctors who reported no surgical specialization. Of the 74 procedures included in this group, 67 were performed by general practitioners, two by board certified internists, four by physicians who were not board certified but reported themselves as giving special attention to a

(*Continued on Page* 188)

"And the leaves of the tree were for healing all the nations." This verse from Revelation, which epitomizes the purpose of William Beaumont Hospital, is captured in the sculpture that appears on building facade.

HOMELIKE PLAN MAKES PATIENTS FEEL AT EASE

Modern Hospital of the Month

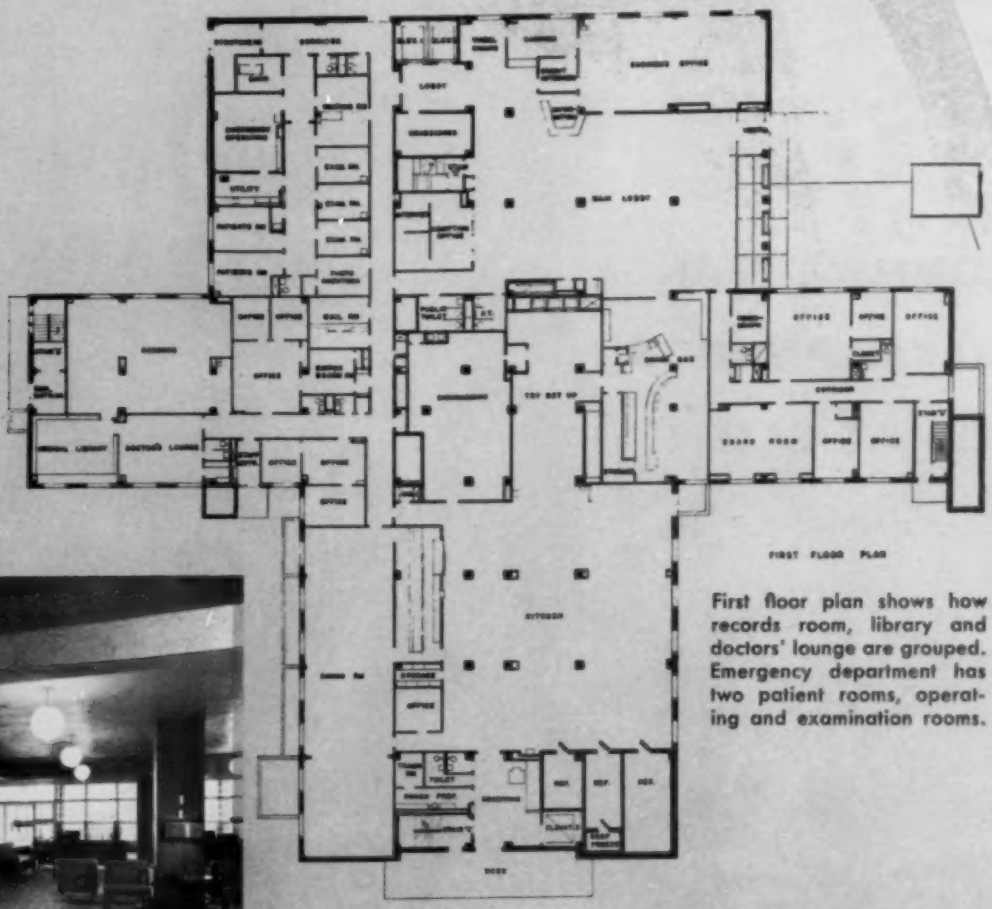
William Beaumont Hospital, described in the following pages, makes use of warm surroundings, gay colors, and even daily menus to help patients recover

THE HOSPITAL IS CAPABLE OF EXPANDING TO MEET ANY FUTURE NEEDS

Owen R. Pinkerman

ALMOST 10 years ago, a group of public spirited Detroit citizens recognized the urgent need for an acute general hospital to serve the suburban area just north of the city of Detroit. Unprecedented industrial and suburban population growth had created the need for hospital services to this area. Fortunately, there was a site available consisting of 105 acres on the main artery that bisects Detroit and nine suburban communities proceeding northward. The land was acquired and the hospital was planned and built with a capacity of 238 beds. William Beaumont Hospital opened its doors to receive patients in January of 1955.

Mr. Pinkerman is director, William Beaumont Hospital, Royal Oak, Mich. Architects were Ellerbe and Company, St. Paul. Consultant was Dr. Christopher Parnell, Ann Arbor.



First floor plan shows how records room, library and doctors' lounge are grouped. Emergency department has two patient rooms, operating and examination rooms.

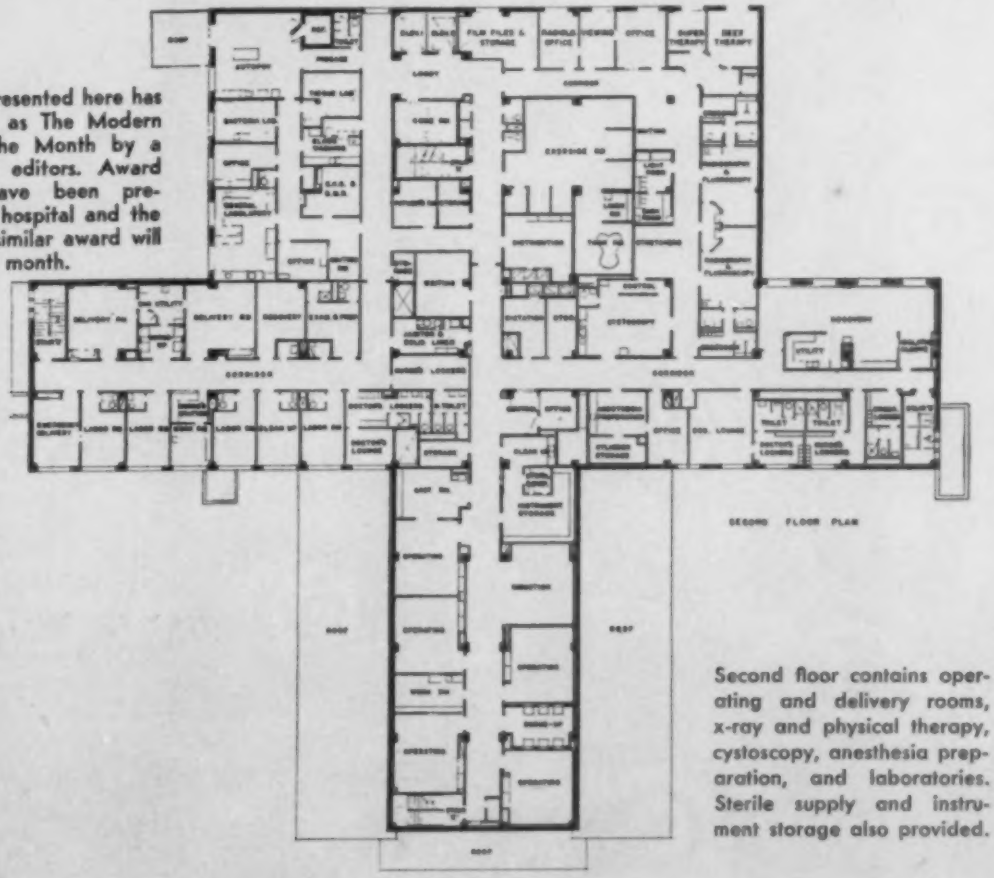
Top picture: Front entrance and part of lobby. Smaller version of lobby is provided on each floor for patients' families. Snack bar, open 24 hours per day, and gift shop are near the lobby. Bottom picture: One of the de luxe private rooms. Another view of the exterior of the hospital is shown in color on this month's cover.

THE WHOLE BUILDING IS DESIGNED TO SPEED THE PATIENTS' RECOVERY

Careful study has been given in original planning to the development of a fine, typical acute general hospital which could be capable of expanding its services to meet any future needs in serving patients of the area, the many new physicians moving into the area, and the tremendous growth of industry in the area. It is noteworthy that the hospital has been well accepted in the Greater Detroit area and has rendered a kind and volume of patient care which has earned for it widespread praise and recognition.

From the moment a patient walks across the deeply carpeted lobby of William Beaumont Hospital for his average stay of five and one-half days, he is met by comfortable, warm surroundings and gay colors. Radio and television are available in his room; he

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made each month.

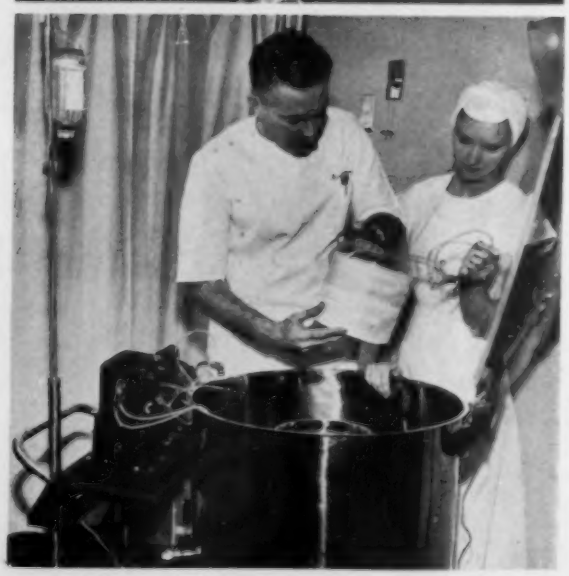


Second floor contains operating and delivery rooms, x-ray and physical therapy, cystoscopy, anesthesia preparation, and laboratories. Sterile supply and instrument storage also provided.

OUTLINE OF CONSTRUCTION COSTS

Total project cost		$4,358,000.00*
No. of beds	240 (planned for 400 additional)	
Cost per bed		18,160.00
Total square feet	164,000	
Square feet per bed	683	
Cost per square foot		22.80
Total cubic feet	2,217,000	
Cubic feet per bed	9,240	
Cost per cubic foot		1.69

*Includes Group I and II equipment.



Top picture: Typical visitor and patient lounge on each floor. Second: Newborn nursery and workroom, on third floor. Third: Partial view of kitchen shows cooking area and equipment. Bottom picture: An artificial kidney is prepared for use in the hospital. A heart center has been established on the fourth floor.

THE LONGEST CORRIDOR IS ONLY 46 STEPS FROM THE NURSES' STATION

is provided a daily menu and other hotel-like accommodations. The whole building is designed to speed the recovery of William Beaumont's patients and to make them happy as possible in the process. They get quick service from teams of nurses for two reasons, which were worked out in the planning. First, the longest corridor in the building is only 46 steps from the nursing station to the outermost room on the nursing floor; second, a patient can communicate directly with the nursing station through a combination microphone and loudspeaker.

There are no wards in this new hospital. All rooms are semiprivate, except for eight deluxe private rooms (see picture). The "no ward plan" was adopted by the hospital's board because it is believed to be a quieter and more restful type of accommodation, yet offers the patient the security of not being isolated or of being with others in time of illness. William Beaumont is one of the first hospitals in Michigan to be completely air-conditioned.

Unusual features include a combination snack bar-gift shop, which never closes and which is available not only to the visitors of the hospital but also to the medical staff and the hospital employes, during the hours the employes' cafeteria is closed.

The basic hospital plan, with a subsequent addition, consists of a basement and five stories and includes 259 beds and 52 bassinets. The foundation was built to provide for an additional five floors of expansion. The "workshop" area, which includes the basement, first and second floors, was designed and built for horizontal expansion, which will eventually fill out to the form of a rectangle. The third, fourth and fifth floors are patient floor areas and are laid out in the form of a cross. Three wings of the cross are devoted to patient care and one wing to elevator service facilities, consultation and teaching rooms, and so on. Expansion of patient areas will be on a vertical plane accomplished by the addition of any number of patient floors to a maximum of five. It is interesting to note that there is a single nurses' station on each 87 bed floor, which provides for an economy of personnel, supply and equipment.

Another outstanding feature, and one of the major requirements of the design planning of this hospital, was the need to provide for an adequate emergency and outpatient facility. Surveys had demonstrated a possible case load of 10,000 visits per year. A special department is built on the first floor of the hospital contiguous to the ambulance entrance. It consists of a complete major operating and treatment room, and four examination and treatment rooms that provide accommodation to seven patients at one time. The department also provided a nursing office, supply room, separate sub-

NOTES ON CONSTRUCTION FEATURES

Service Facilities: Existing service facilities are adequate for an additional 150 to 200 beds. Since all service facilities are on the lower floors any additional expansion of these facilities has been planned to be accomplished by expanding horizontally on these lower floors. The bed expansion is vertical.

Emergency Lighting and Power: An automatically started emergency plant is provided to serve selected lighting, appliance and power loads. The plant consists of a 100 kw. gasoline-engine driven generator. The following loads are served by the emergency plant: operating and delivery rooms; stair and exit lights; fire alarm system; nurses' call system; lighting at nurses' stations and boiler control panel, selected lights, and receptacles in the power plant.

Doctors' Call System: A voice paging system is provided that permits low-level paging throughout the hospital. Facilities are provided for paging in eight separate zones including delivery section, surgery, basement and the first to the fifth floors.

Nurses' Call System: The nurses' call systems are combination visual and two-way audible systems. Call lights are provided in the corridors at the entrances to patients' bedrooms and microphone speakers are provided at the bedside stations for direct two-way communication with the nurses' stations. The central control units are equipped with selector switches which automatically select calls in the order in which they are registered.

Fire Sprinkler Protection: Automatic sprinkler fire protection is provided in specific areas, such as storage, janitors' closets, and laundry. In addition, the hospital is piped with a standpipe system having cabinets with small hoses and valves for large hoses connected to the system.

Water Softening: Water treatment equipment consists of a large wet salt storage basin, sodium zeolite exchangers, dealkalizer and a mixed bed deionizer. Deionized water is piped to stills, water sterilizers and laboratory outlets. The dealkalizer is for boiler feed water treatment after sodium zeolite softening. The laundry hot and cold water is softened to zero grains; the general purpose hot water is blended to approximately 5 grains and the softeners are fully automatic regeneration type.

Air Conditioning: With the exception of the laundry area, mechanical equipment rooms, and the mechanical service building containing boilers, water heaters, refrigeration equipment, water treatment, and transformers, all areas are air-conditioned on a year-round basis. All air conditioning systems provide tempering, filtering and humidifying through the winter; cooling, filtering and dehumidifying through the summer, and fresh air exchange and individual automatic room control on a year-round basis. Systems in all but patients' rooms are all conventional velocity central type with forced hot water reheat control. Patients' rooms employ the so-called fan type room unit system in combination with a primary air system connected to the units. Each room is individually controlled by a summer-winter stat which regulates flow of cold water in the summer and hot water in winter. All systems employ the orificed duct design feature which eliminates dampers, and balancing of air volumes. This orifice design stabilizes the air flow regardless of building stack effect, wind pressures and any volume variations which could otherwise occur with varying air densities from heating to cooling. It gives an initial air balance at job completion unobtainable with other systems.

sterilizing room, and a rather small visitors' waiting area.

In the first two years of operation and with a growing case load, the clinic had reached nearly 18,000 visits per year. It became evident that expansion of this area could not await a major expansion program. Accordingly, a special unit consisting of two floors was built adjoining the original emergency-outpatient suite. Remodeling part of the original unit provided for a treatment area for 13 patients and a short-stay unit consisting of 21 beds, which is operated in connection with the emergency and outpatient service. The maximum stay permitted in this new unit is 24 hours. Medical supervision is provided to ensure that all patients admitted to this unit are transferred to an inpatient status on the upper floors, treated and discharged, or transferred to another facility within 24 hours of the time of their admission to the unit.

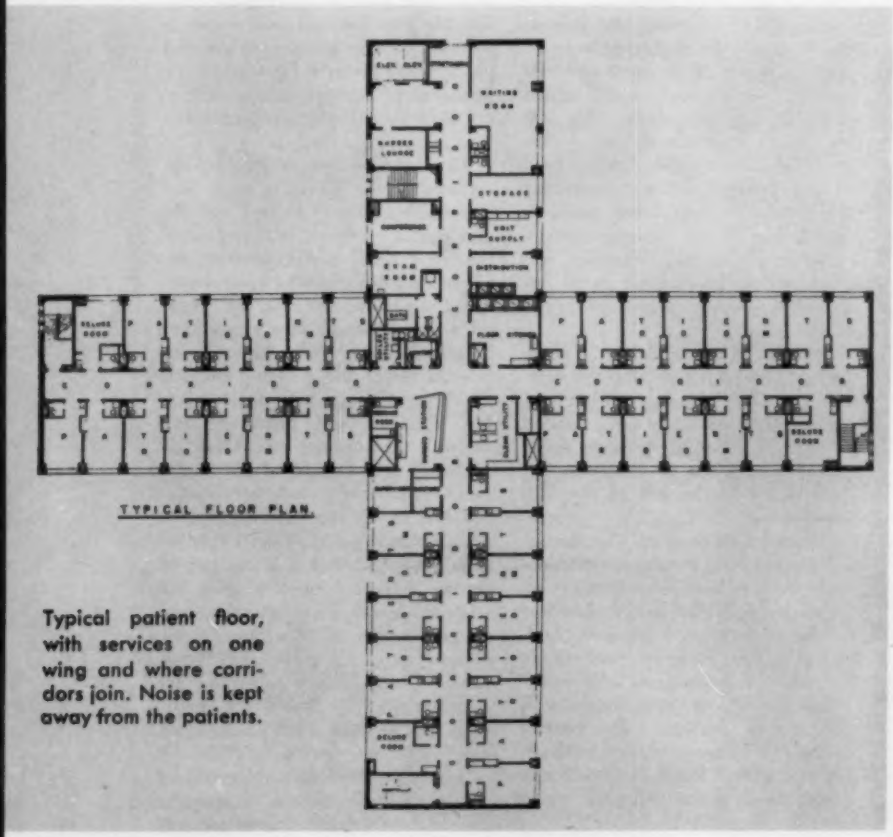
This expanded unit will have provided care for 25,000 emergency and outpatient visits in its first full year of operation and the short-stay unit is currently accommodating 400 admissions per month. One major advantage of this new addition has been the release of medical and surgical beds on the inpatient floors, which have previously been "held for emergency use." Another advantage has been the opportunity to bring together and train specialized nursing personnel skilled in the care of traumatic and other acute admission problems. A special training program is undertaken with this personnel. The hospital is convinced of the many advantages that this additional unit has provided.

About one year after the hospital's opening, the auditorium originally built in the basement was converted to a department of medical physics, which has provided space for a complete radioisotope program for both diagnosis and therapy. It is operated by medical physicists in cooperation with and under the supervision of a radioisotope committee of our medical staff.

The second floor of William Beaumont Hospital is often referred to as the doctors' workshop, and includes a general surgical pavilion consisting of five major operating rooms, an orthopedic and cast room, and two cystoscopy rooms. The x-ray department is immediately adjacent to this area and includes radiotherapy and diagnostic x-ray service with a total of five x-ray examination and treatment rooms. The clinical laboratory and pathology department is also located on the second floor and is completely departmentalized. The physical therapy department is located in the center of the second floor and convenient to elevators. The obstetrical surgical suite is also located on the second floor and consists of three modern, fully equipped delivery rooms, in addition to twelve labor beds. Just outside the obstetrical surgical suite, the hospital has a beautifully decorated "fathers' room," which has photomurals on the walls. A television set is provided and the room is always well stocked with magazines.

The board of trustees of the hospital is currently working with the hospital's architects, Ellerbe and Company of St. Paul, and will soon review a major expansion program that will provide for the growth of the hospital by the addition of new patient floors and horizontal expansion of the workshop area. The architects are recommending expansion as a part of a master plan program that will assure that any new growth of the hospital will provide complete flexibility in line with current thinking on the matter of progressive care of patients. A constant care unit also will be proposed. Expansion of acute care facilities will be recommended and consideration is being given to the need for subacute and diagnostic type facilities.

The original hospital structure, which is new, has proved very successful and serviceable in its three and one-half years of operation, and the possibility of expanding the basic chassis by any one of several alternative approaches to provide for programmed growth in the direction of total health care has been very well conceived. We should point out also that growth from this basic plan to an enlarged acute, general unit, without adding services not now being rendered, would also be possible. We can therefore conclude flexibility, efficiency through planning, and uncluttered design features have provided an excellent modern community hospital capable of growing with whatever future is determined for it without serious concern about obsolescence. ■



Typical patient floor, with services on one wing and where corridors join. Noise is kept away from the patients.

How one hospital enlisted the cooperation of its doctors and nurses in developing an "aseptic conscience" and made them all realize that

It takes the whole staff to fight staph

Charles V. Wynne

WHEN the surveyor from the Joint Commission on Accreditation of Hospitals studied Waterbury Hospital, Waterbury, Conn., in 1954, he commented that all infections of clean surgical cases should be listed and thoroughly investigated. After that inspection, our medical staff, in its monthly analysis of professional performance, gave an accounting of infections in clean surgical cases, and (like many other hospitals, we suspect) found few of them.

At that time, however, we did develop policies for surgeons, nurses and other personnel in the operating room; these were the standard personnel policies that exist in most modern hospital operating room suites. We also took a long look at existing equipment and instituted programs to have our operating room areas and anesthesia storage areas made safe places, in conformance with established practices.

In 1957, we were surveyed again by a representative of the Joint Commission, and again attention was drawn to the fact that all infections of clean surgical cases should be listed and thoroughly investigated and that statistics should be maintained. We reviewed our listing and statistics, and, instead of becoming overconfident at the low rating we enjoyed, we decided to develop an awareness of aseptic technics.

When we revised our medical staff by-laws in 1957, we included many of the component parts of our existing by-laws which, in one instance, said the following:

"The chief of staff shall each year, upon assuming his duties, appoint a hospital health officer. It shall be the duty of the health officer to see that proper precautions are taken to prevent the introduction into, or spread within, the hospital of infection through employes, sanitary defects, or other sources of infection. He shall make a sanitary inspection monthly of the entire hospital plant and its immediate environs. He shall render a monthly report of his findings and recommendations including violations of the local and state sanitary and health laws. This report shall be sent to the chief of staff, the medical staff executive committee, and the administrator of the hospital, whose duty it shall be to carry out his recommendations as expeditiously as possible."

Committee Appointed

After we revised the medical staff by-laws, a special committee, called the study committee on hospital infections, was appointed by the president of the medical staff on the suggestion of the medical staff executive committee. This committee includes the administrator of the hospital, a representative of the medical division, surgical division, and department of obstetrics and gynecology, and representatives of the nursing, dietary and housekeeping departments, with the hospital health officer as chairman.

The committee meets on the first and third Tuesdays of each month. It is interesting to note the channel of communications between this committee and the medical staff executive committee for transmittal through the joint conference committee to the board of trustees.

The committee, being actively interested in the reason for the low infection rate of the hospital, set about to study the situation. It also began to investigate large areas in the hospital where the staphylococcus infection seemed to exist.

It made studies and cultures of the nursery, and made cultures of nursing staff personnel and pediatricians who visited the nurseries. It found incidences of staphylococcus infection.

The committee made studies of technics used in cleaning the nurseries, of equipment and supplies used, and of the manner in which these supplies were prepared, including autoclaving and laundering. It made recommendations to improve conditions in this area.

At the same time, it inspected the forms used to report hospital infections on the nursing divisions, and recommended that these be revised and implemented to include other than wound infections. The revised forms are now in use.

It is interesting to note the way in which the hospital obtained the staff's cooperation in filling out the forms.

For many years, it has been the custom in the hospital to conduct a head nurses' meeting, at which lunch is served, every Monday noon. For an hour or an hour and a half thereafter, there is a round table discussion of nursing service matters. The infection report forms were discussed with this group, all questions were answered, and the group recommended that the revised forms be put in use at once.

Thus, the recommendations of the

Mr. Wynne is the administrator of Waterbury Hospital, Waterbury, Conn.

study committee on hospital infections were translated to the group most concerned and made acceptable to it, and a cooperative spirit was gained to acquire additional information and to implement control of infections.

At the same time, the medical staff, in its executive committee, pondered the growing concern on the part of the public, the scientific journals, and health personnel in particular about the existence of Staphylococcus aureus in hospitals. It recommended that lectures be given to department heads, head nurses, and supervisors to make them aware of the need for developing an "asepsis conscience." This idea grew and took the form of a panel discussion.

An invitation to the meeting was given to all hospital personnel, the hospital aid society or its volunteers, the board of trustees, the medical staff, the private duty nursing staff, and allied hospital agencies in the community.

There was an opening statement by the moderator, Dr. Joseph O. Collins, hospital pathologist. He was followed by Dr. Joseph L. Hetzel, hospital health officer and attending pediatrician, who discussed the background of hospital infections. Dr. O. J. Bizzozero, acting chief of staff and attending

CIRCULAR WASHBASIN PLACED IN THE CENTER OF THE NURSERY REMINDS

KEY TO FLOOR PLANS (Figs. 1 and 2)

1. Bassinet
2. Bedside cabinet
3. Table, 16 by 24 in. (for infant scale)
4. Lavatory with gooseneck spout and knee control (Fig. 1)
4a. Circular sink with foot controlled valve (Fig. 2)
5. Wastepaper receptacle
6. Sanitary waste receptacle
7. Linen hamper
8. Pass window with shelf and sliding sash (Fig. 2)
9. Table, 24 by 36 in.
10. Nurses' desk with chart rack for 8 charts
11. Telephone outlet
12. Straight chair
13. Hook strip
14. Sink in counter with gooseneck spout and knee control
15. Counter, 36 in. high, with cabinets below
16. Instrument sterilizer, 4 by 6 by 16 in.
17. Wall cabinet
18. Single element hot plate
19. Refrigerator, 6 cu. ft.
20. Counter, 36 in. high, open below
21. Stool
22. Chart rack for 2 charts
23. Incubator
24. Gown hook
25. Cubicle partitions, 5 ft. 6 in. high, clear glass in upper panels (Fig. 1)
26. Corner cabinets (Fig. 2)
27. Dutch door (Fig. 2)

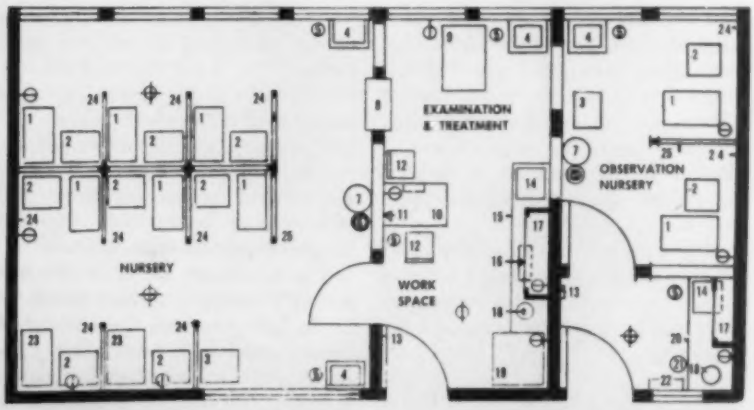
Fig. 1 (right) shows the location of lavatories at some distance from the infants, an arrangement that necessitates much walking on the part of nurses. In contrast, Fig. 2 (opposite page) shows an arrangement that makes handwashing facilities the focal point of the newborn nursery.

PLANS for hospital nurseries to provide adequate facilities for care of newborn full-term and premature infants have been aimed primarily at minimizing potential cross-infections and facilitating recommended routine care. Good nursery technic, as has been emphasized by the American Academy of Pediatrics, demands that nursing and medical staff members who care for infants wash their hands before and after handling each infant or equipment assigned to an infant, in order to reduce spread of hand-borne infection. Compliance with prescribed handwashing procedures necessitates not only appreciation by nursery personnel of the precise technics required and their importance, but also a sufficient number of readily accessible facilities. Even thorough understanding of the importance of handwashing and acceptance of prescribed routine do not obviate the temptation to cut corners where structural inconveniences require excessive expenditures of time and motion for the maintenance of handwashing standards.

An existing plan of a nursery for a 50 bed general hospital, as recommended by the Children's Bureau, U.S. Department of Labor, is shown in Figure 1. Plans for larger hospitals are, basically, multiple reproductions of this standard design. With this arrangement lavatories are located in adjacent corners of the nursery and are at some distance from the infants. The linen hamper and sanitary waste receptacle are located next to the wall and at some distance from the lavatories. This arrangement necessitates considerable walking in order to wash hands properly when attending to the consecutive needs of infants, and materially increases the amount of time spent per infant.

A more functional nursery design to provide increased accessibility of handwashing facilities is presented in Figure 2. The plan features a centrally located circular sink, spacing of infant

Fig. 1 — Conventional Nursery Design



physician in internal medicine, discussed the medical aspects of staphylococcus infections, and Dr. Clarence Cole, acting director of surgery and attending surgeon, discussed in detail the surgical aspects of these infections. Aseptic technics in the operating room and the nursing divisions were outlined by Irene Labaha, operating room clinical supervisor, and Mrs. Roberts Blakeslee, assistant director of nursing. Winifred Burns, executive housekeeper, told the audience about the housekeeping aspects of the problem, and Dr. Hetzel reemphasized the local control program.

At the end of the panel discussion, considerable time was devoted to audience questions. Dr. Collins then summarized the presentations as follows:

"Although infections in general are much better controlled today than they were before the advent of antibiotics, nevertheless, certain bacteria —particularly, some strains of staphylococci—have emerged resistant to antibiotics and, therefore, require other means of control.

"There is need for continuing research in order to learn more about this phenomenon and about the particular organism strains that manifest it.

"The resistant strains tend to focal-

NURSES AND DOCTORS THAT ASEPTIC TECHNIC CENTERS ON HANDWASHING

D. J. Schliessmann and James Watt, M.D.

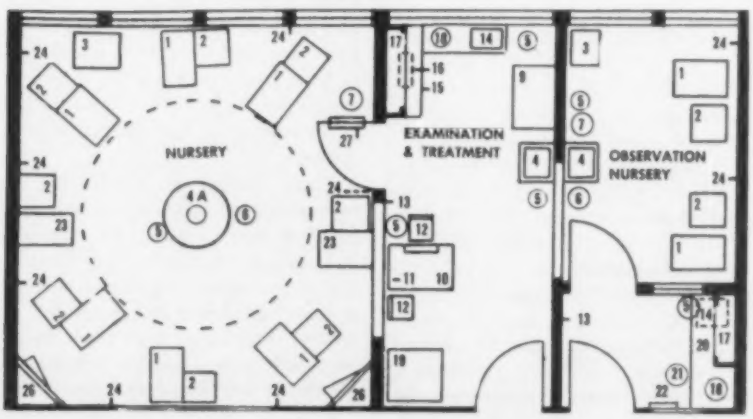
units about the sink periphery, and elimination of cubicles. In this design the centrally located circular sink, with foot operated valve, is approximately equidistant from all infants, is accessible from all directions, and can be used by several people simultaneously during peak periods of activity. The circular sink may be designed to permit installation of wastepaper and linen receptacles beneath the lavatory and around the periphery of the pedestal. This arrangement requires nursery personnel to return to the lavatory to dispose of soiled linens and diapers, thus enhancing the probability of their adherence to prescribed handwashing technics. Handwashing facilities are thereby made a focal point of operations within the nursery, and by their proximity to the infants the psychological importance of handwashing may be increased.

Arrangement of the cribs or incubators in a circular or elliptical pattern about the lavatory provides increased space for individual bedside nursery care while equalizing the distance between the infant units and the lavatory. Elimination of cubicles provides greater flexibility within the nursery with marked fluctuation in patient numbers in the event of high census and increases ease of thorough cleaning. An adaptation of the circular sink to a nursery with cubicles is not shown since it has been stated that "individual cubicles, or partitions, not only increase cleaning difficulties but do not prevent cross-infection. They are therefore not recommended."

It should be noted that plans for the examination and treatment room as well as for the observation nursery have been altered in the proposed design. The entrance to the nursery from the examination and treatment room is relocated to provide a relatively indirect access to the nursery from the outside corridor. Further to encourage frequent handwashing, the lavatory is located adjacent to the examining table so that nursery personnel and visiting physicians are required to pass the lavatory before reaching the examining table or entering the nursery. The arrangement of the lavatory and the nurse's desk has the effect of subdividing the examination room into a treatment or examination room and an entrance chamber.

In the observation nursery the lavatory has been placed on the side wall for greater accessibility to each crib. For economy of installation, the lavatory in the observation nursery and the lavatory in the examination and treatment room are placed back to back, thereby permitting the use of a common soil pipe and multiple plumbing fittings. Adequate space is provided for location of additional equipment as needed by the individual hospital. ■

Fig. 2. — Suggested Nursery Design



D. J. Schliessmann

Dr. James Watt

Mr. Schliessmann is chief, state aids section, technology branch of the Communicable Disease Center, Public Health Service, located in Atlanta. He has been with the Public Health Service since 1941. Dr. Watt is director of the National Heart Institute, a position he has held since 1952. He received his medical degree from Johns Hopkins School of Medicine, and a doctor of public health degree from Johns Hopkins School of Hygiene and Public Health.

WOUND INFECTION FORM

(No. 1—No. 9) The following questions are filled in by the head nurse on all wound infections of clean cases and this form is to be sent directly to the operating room supervisor.

1. Name of operating surgeon .....
2. Date and hour of operation .....
3. Name of operation .....
4. Presence of any pyogenic skin infection in the patient or in the attending ward personnel (Identify) .....
5. Presence of other patients with infected wounds in the same room or ward (Identify) .....
6. Postoperative day on which the infection was discovered .....
7. Nature and amount of drainage .....
8. Were cultures made and what was the organism reported? .....
   Sensitivity if done .....
9. Were antibiotics used preoperatively or postoperatively or both?
   Identify Type: ..... Dose: ..... Dates: .....

NOTE: The following questions (No. 10—No. 16) are to be answered by the operating room supervisor and sent to the nursing school office. Photo copies will be sent to the chief of division of surgery and the operating room supervisor.

10. Type of infection .....
11. Type of suture material .....
12. Were there any difficulties with the sponge count? .....
13. Name of assistant? .....
14. Name of nurses assisting .....
15. What other operations have been done in the same room on the same morning previous to this operation? .....
16. If other wound infections are known to have occurred on one of the patients operated on the same day, name the personnel concerned and the organism found .....

NONSURGICAL INFECTIONS

Name of patient ..... Date admitted: .....
Original diagnosis .....
Date secondary infection noted .....
Diagnosis of secondary infection .....
History of exposure before or after admission .....
.....
Antibiotics or specific treatment used since admission .....
Bacteriology of secondary infection organism sensitivities .....
.....
Disposition of patient .... Isolated: .... Discharged: .... etc. ....
Signed: ..... R.N.
Signed: ..... M.D.

OBSTETRICAL INFECTIONS

Name of patient ..... Date admitted .....
Method of delivery of baby ..... Date infection noted .....
Method of delivery of placenta ..... Date reported .....
Patient is nursing? ..... Yes ..... No .....
Type of infection: Breasts
Episiotomy
Wound infection (Cesarean)
Puerperal sepsis
Genitourinary
Phlebitis
Upper respiratory tract infection
Others
Bacteriology of secondary organisms and their sensitivities: .....
Antibiotics or specific treatment used: .....
Disposition of patient: .....
Signed: ..... R.N.
Signed: ..... M.D.

ize in hospitals, so that eventually a high percentage of hospital personnel may harbor the organisms and thus may act as carriers.

"We learn that the organism is found everywhere: on beds, bed linen, bedside tables, and all the nonsterile articles in constant everyday use, as well as on the hands, skin, mouth and nose of most people working in hospitals.

"Particularly subject to risk are: (1) newborn infants and their mothers, (2) aged debilitated patients, (3) surgical patients, (4) those on steroid therapy, and (5) those requiring catheterization.

"Control measures require continuing emphasis on meticulous, aseptic isolation and surgical wound dressing technics, as well as on good housekeeping to reduce dust-borne infection. Since the carrier rate is so high among hospital employes, nothing can be done along the lines of restricting hospital carriers, but, rather, each individual must assume personal responsibility for his own understanding of the problem and for learning and practicing the excellent aseptic technics outlined by the nursing members of the panel.

"Each individual must ask himself many times a day and after every service to a patient, 'What contaminated material have I touched? Did contaminated material touch my uniform or shoes? How can I avoid transferring the contaminating bacteria to the next article I touch or patient I visit?'

"If we all as individuals ask ourselves these questions often enough, we eventually reach a point where we subconsciously shun those practices which may transfer infection from ourselves to a patient, or from one patient to another, and subconsciously practice the aseptic technics without break or deviation.

"What is said in this regard must be made to apply to all auxiliary workers and volunteers who visit patient areas, and steps must be taken to orient each of them to the problem and to proper aseptic technics. This will assure use of an acceptably low infection rate in our hospital."

Thus, instead of maintaining an overconfident attitude toward the Staphylococcus aureus that does exist in hospitals, we believe that developing an awareness for aseptic technics and understanding the need for an asepsis conscience does much to assure each person that the best way to develop it is to live it as a way of life.

Ground Rules for People Who Make Policies

The essence of formulating policies can be summed up in four general rules: (1) Policies must be practical; (2) they must be relevant; (3) they must be consistent; (4) they must be detailed and still be quite flexible

S. G. Hill

THE most important aspect of administration is the formulation of policy, and the process of formulating policy is usually referred to as planning. These two terms are, then, almost synonymous, but not quite. Planning envisages rather the preparation of blueprints for some future enterprise, whereas policy formulation is a continuous process applied to an existing operation. This is, however, a very fine distinction, and for most practical purposes the two concepts may be regarded as quite similar.

The broad purpose of policy formulation is to define the end or objective of the operation. To this extent, policy is distinguished from the other aspect of administration, that is, executive management, which concerns itself with the means of achieving the ends or objectives which have been defined or formulated by policy. It is important to realize that policy is not an absolute concept and it can be applied widely or narrowly.

For instance, the broad policy of a hospital is to give care and treatment to its patients. Within this broad framework, however, it may have many other subsidiary policies. For example, it may be the policy of the hospital not to be too demanding regarding the payment of bills by its poorer patients; it may be its policy to purchase only local products as far as this is practicable, or it may have a policy of demanding certain qualifications in respect of certain types of labor. All these matters are policies; all are subsidiary to and not in any sense in conflict with the main policy of the hospital to provide care for patients.

What considerations, then, enter into the field of policy formulation? The first and most obvious consideration is surely that the policy, whether it be broad or narrow, must be practicable and capable of achievement. This is an important consideration, because too often the mistake is made of assuming that policy is a matter for the idealists, whereas management is a matter for the practical man. Although policy is much concerned with ideas, it is not correct to regard it as being the realm of ideals, unless, of course, they are strictly practicable ones. It is, then, clear that those who make policy or plans must be practical, experienced people who must know in what direction they are going and, more important, must know that the particular direction they have chosen is a practicable one and not blocked by insurmountable obstacles.

Experience in this sense includes judgment, that is, the knowledge of what will work and of what will not work, the estimation of cause and effect. This involves a knowledge of logistics, or in other terms, the everyday practicalities of existence. To use a rather obvious example, there would be little point in building a hospital in a particular spot which happened to have a pleasant climate if, when the hospital was built, it was so inaccessible that neither patients, visitors nor supplies could readily reach it. Here the policy of building a hospital in a pleasant place would have to be modified by the equally valid policy of building a hospital that was accessible.

The most formidable factor governing most policies is, regrettably, that of finance. We could, most of us, be expert planners if only we had unlimited money and resources. These commodities, however, never are unlimited and, therefore, a practical aspect of any planning is to produce results within the framework of the resources that are available for the project.

The second important consideration in policy formulation is that of relevance. This might seem a somewhat surprising comment, but it is nevertheless true that when plans and policies are being produced it is extremely easy for the true purpose of the project to become overlooked or obscured. All those who are familiar with hospital planning know just how easy it is to set out to plan a new outpatient department and, perhaps, end up with a new children's ward. This is, perhaps, a rather extreme example, but it is surprising how easily we can be distracted in our policy formulation and planning. One thing leads to another and before we know where we are, everyone's eye has somehow been taken off the ball. It is, accordingly, extremely important as planning and policy formulation proceed that one should constantly ask oneself the

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question: Are we still going in the right direction and will we eventually end up by achieving what we set out to accomplish?

The third factor in policy formulation and planning is that of consistency. In other words, new policies must be consistent with existing policies and not give rise to uncertainty because of apparent conflict. Rarely is sufficient attention paid to this point, and most of the time it seems a matter of detail, but it is important that clear distinction should be drawn between a change of policy, on the one hand, and, on the other hand, a departure from a still valid policy in special or exceptional circumstances. For example, a hospital may have a policy of employing only local labor, but it may find that one or two highly specialized posts require the importation of labor from elsewhere. It is quite important that it should be clear to the hospital and all its employes whether this employment of labor from elsewhere means that the policy of employment of local labor has been changed, or whether that policy still holds good and the one or two appointments made from elsewhere were exceptional.

There Should Be No Question

If it is found necessary to depart temporarily from a valid policy, then it should be made clear that the departure is only temporary and exceptional and the basic policy is still valid. If, in fact, it is the basic policy which is to be changed, then that fact, as such, should be made clear. What is quite indefensible is to act in a way which might mean a change of policy or a temporary departure, but to leave it open to question which of those two is intended. As a matter of routine, all existing policies should be kept under review, not only from the point of view of eliminating conflict with new policies, but also to make sure that existing policies still hold good. Even if a policy is not in conflict, it is still a criticism if it is so far out of date that it has ceased to make any sense.

The fourth general rule which may be propounded in policy formulation is that any policy should be sufficiently detailed to be clear and precise, but should not be so detailed that it operates to curb executive initiative. This principle is much simpler to state than to apply, and, of course, everything depends upon circumstances of the particular case, but it can be said that, on the one hand, a policy which attempts to foresee every detail and to provide for it in advance is mistaken, while, on the other hand, a policy which is so broad and general that it gives rise to uncertainty in application is equally defective. The aim should be to lay down sufficient principle and guidance for any intelligent executive to absorb the idea and concept and rationale of the policy, but to leave sufficient scope for the intelligent application of the principles laid down to allow for the necessary, and inevitable, divergence between the theory of policy and the practice of implementation.

For instance, it will probably be the general policy of an acute general hospital to have a certain margin of beds always available for the admission of emergencies. In practice, this policy will probably mean that a certain fairly definite number of beds is available in each ward or department of the hospital. These figures, however, should not be incorporated in the policy, because there will be many occasions upon which they must be changed. If the hospital has had a heavier than usual load of emergency admissions, the margin may have to be narrowed, and a certain element of chance taken that further large numbers of emergencies will not arrive; if, on the other hand, some particularly hazardous local event, such as a car racing meeting, is to take place, then the margin for emergency admissions may be slightly extended to make provision for what will probably be a heavier than normal emergency intake. Several other possibilities which affect this margin will be readily apparent, and the main point is that the general policy or principle should be merely that *a sufficient margin should, at all times, be maintained for emergencies*. Exactly *what* that margin is should be a matter for *implementation* of the policy, and should *not* be incorporated within the policy itself.

Bearing in mind the general principles listed, some thought may now be given to the mechanics involved in policy formulation. The golden rule in this matter, and indeed, one which applies to all aspects of administration, is that assumptions should never be relied upon when facts are available. This rule is all too often ignored, quite often on the assumption that, policy being essentially something within the realm of ideas, facts are neither available nor necessary. This is completely untrue, and there are, indeed, few situations which demand planning and policy formulation and for which some facts are not available. For example, if it is intended to build a hospital for ear, nose and throat operations in a locality which has not previously had such a hospital, it would be quite unwise to pursue this project on the assumption that there were, shall we say, 20,000 children in the locality and that three-quarters of those would require tonsil and adenoid operations. The first step would be to assess with some accuracy just how many children there were in that locality and how far the present demand for tonsil and adenoid operations was being met elsewhere. If it could be assessed that some 20,000 children were not well served for tonsil and adenoid operations, it would still be imprudent to guess at the number of them likely to require the operation. Not only is this imprudent, it is quite unnecessary, because it is a matter of no great labor to discover approximately how many children per 1000 of population require tonsil and adenoid operations.

All planning, then, must be based upon facts and, in general, it is not true to say that the operation is a new one and the facts are not available. The operation may, indeed, be a new one, but it is quite exceptional if most of the relevant data are not obtainable from somewhere.

Then, Interpret the Facts

Having assembled the necessary facts, the next task is to assess and interpret them, and this involves, again, experience, judgment and all-round administrative ability. Nevertheless, anyone who is involved in any way in policy formulation should know as part of his job what facts he should take into account and how they should be assessed and interpreted. When the relevant facts have been assembled, assessed and interpreted it remains only to take the necessary decisions, and there you have your policy or your plan.

An important further operational consideration involved in policy formulation is a clear understanding as to who may, in what circumstances, alter or depart from that policy. It is a natural assumption that those who make policy alone may change it, but this assumption is not always intended, and it is not uncommon for a governing body to lay down policy but to be quite prepared that its executive chief

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Nurses' training must fit the nurses' jobs

The greatest obstacle to meeting demands of the public for nursing service is nurses' treatment of nurses — their failure to be fair and impartial to personnel under their jurisdiction. Teaching nursing executives to live and let other nurses live is the greatest challenge to modern nursing

Edith A. Aynes, R.N.

MEMBERS of the medical profession are beginning to take an interest in nursing education. They realize that antibiotics have not eliminated the need for aseptic technics; that drugs and solutions can be dangerous when administered by the uninformed, and that producing a safe attendant who can carry out orders in this highly complex medical world is an involved educational process requiring more than a nurse's aide course to accomplish.

The average physician's attitude toward nurses is formed during the first few months he interns on a hospital ward. Some physicians remember with warmth and affection the understanding, considerate nurses who went out of their way to help them—to keep them from making mistakes that the chief of service could crucify them for making. But many physicians were not so fortunate. The Susie or Mary who couldn't stand interns, who tried to throttle them and had no hesitation in using her experience and knowledge to embarrass the young doctors at every turn, can take a great deal of credit for creating the impasse in nursing that faces us today. Not only did these nurses alienate doctors; they drove young nurses from the field at the same time!

But whether the doctor dislikes nurses or not, he needs them; his patients need them; and because anybody can become a patient, the public needs them.

It is one thing for a doctor to write an order, and quite another thing for that order to be carried out without damage to the patient. Most doctors imagine that the people who attend patients learn to perform procedures by osmosis, since this is the way the intern had to learn them. For example, the doctor does not hesitate to write an order to catheterize a patient and then go, unperturbed, to the operating room, never pausing to learn whether the person who, of necessity, must carry out that order knows the importance of aseptic technic — or indeed has ever heard of the word.

Nursing controls slip because, under our present system of nursing education, we are training 84 per cent of our nurses to give direct patient care but as soon as they graduate, because of the shortage, they become coordinators of nursing efforts on busy wards. The time has come for doctors, hospital administrators, and nursing leaders to recognize that education for the nursing effort involved must fit the job with enough workers and leaders to care for patients safely.

Traditionally, nursing has played a subservient role to medicine, and doctors have liked it that way. Nurses liked it that way, too, as long as the nursing care of the patient was uncomplicated by the medical aspects of nursing care and the doctors had an authoritarian control over the students who went on the hospital wards to learn nursing as well as over the women who graduated.

But as medical progress marched into specialization, and laboratory and x-ray examinations became the means of diagnosis, replacing the doctor's touch, see and smell technic, which required his presence on the ward, the subprofessional, the allied professional, the coprofessional and the nonprofessional invaded the patients' sanctuary — all with a perfect right to be there. Nursing's role in the hospital became confused, and, with opportunities opening outside the hospital where the nurse could attain a stable, independent and respectable status as a professional individual, nurses moved into public health, industry, organization work, research, the armed forces, and government bureaus. The nurse who stayed in the hospital found diminishing status, little authority, and very little job satisfaction. She still occupied a subservient place, but now she was subservient not only to the doctor, but to the hospital administrator and others who moved increasingly between her and the physician over whose patients she supposedly watched.

What do we mean by nursing?

The term is confusing at best, but clarification can be achieved by investigating the difference between nursing as it was conceived more than 100 years ago and nursing as current nursing leaders describe it.

"Nursing," wrote Florence Nightingale, "has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet — all at the least expense of vital power to the patient."

This appears to be what the patient

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still needs, and he needs to receive it with the same skill, compassion and understanding a mother provides for her child.

But what has happened? Almost anybody administers medicines and applies poultices; the dietitian selects and prepares the diet; the kitchen maid puts it on a tray; the ward aide or orderly carries it to the patient; the housekeeping department outlines the routines for cleanliness; the ward maid and janitor dispense it; the engineers provide the warmth — and the air conditioning; the electricians supply the light; the fresh air is anybody's responsibility and "quiet" is achieved by means of a few 6 inch signs posted near the elevator for the information of visitors!

Nursing today conceives of its role as follows:

"Nursing is one of the services for the care of the sick, the prevention of illness, and for the promotion of health which is carried on under medical authority. Nursing is designed to provide physical and emotional care for the patient; to care for his immediate environment; to carry out treatment prescribed by the physician; to teach the patient and his family the nursing care which they may have to perform; to give general health instruction; to supervise auxiliary aides and coordinate the services of other workers contributing to patient and family care. This service may be given in hospitals or other institutions for the care of the sick, in homes, in community health agencies, in industries, or in schools."

So runs the report (1952) on the program of "Temporary Accreditation of the National Accrediting Service."

No one who knows anything about the demands being made upon nurses these days will take issue with this concept, but if schools of professional nursing are designed to create this product, who is training the person Florence Nightingale was talking about?

Unfortunately, most of our eleven hundred and some-odd schools of professional nursing are attempting to educate both levels with the same curriculum. This is like expecting a Shetland pony to win at Pimlico.

Nursing, being one of the earliest occupations for women outside the home, first brought women into contact with men — mostly doctors — in a different role than that of mother, sister, wife, daughter, sweetheart, friend or housemaid. If nursing were to become a trained occupation, it had to be made acceptable to doctors, because they controlled the hospitals. If nursing were to attract decent, genteel women, it also had to offer something tangible to the individual to make it attractive: something that decent women could have pride in doing and, at the same time, maintain their self-respect.

To change the idea that genteel women could not enter work outside the home with dignity required something to which women could be dedicated. Doctors did not relish the idea that women dedicate themselves to become assistants to doctors, but dedication of a woman's life to the care of patients was relatively easy to imagine: the mother instinct, the humanitarian needs of people, the golden rule, even Christ's own role as the Good Samaritan were evidence that nursing was a noble undertaking for women who would be useful.

This was the beginning of the parting of the ways between the medical profession and what has been developing as the nursing profession. The nurse must have, at one and the same time, respect for herself and

NOBODY WANTS A NURSE TO BE A LEADER

IN 1900, Clara Weeks, writing the first American textbook on nursing, stated: "A prejudice against the instruction of nurses was entertained at the outset by some of the medical profession who feared that educated nurses would trench upon their own province, and, if they were taught to know one drug from another, would immediately proceed to the practice of therapeutics on their own account."

But the ratio of women entering nursing who could become leaders without leadership training were too few at the turn of the century for nurses to argue their problems effectively with doctors. A percentage of these women were true visionaries without whose guidance nursing would never have survived. Some were idealists who concentrated on refining the "profession" of nursing without concern for its function as a "cooperating" profession. A large percentage were followers of idealists who, because of their authoritarian training, neither thought for themselves nor dared to question the rulings of the superior over them —whether doctor or nurse. The remainder just wanted to take care of patients.

Leadership qualities were not only frowned upon, but it was considered not even desirable to include in nursing school curriculums, even for the bedside nurse who had the proper attitude, the teaching of management skills or the psychology of handling people. Schools taught two things: the mission of professional nursing, and subservience to the medical profession—the irresistible force and the immovable object.

"When you have once undertaken the care of a sick person," wrote Miss Weeks, setting forth the irresistible force, "his welfare is, of course, understood to become your first consideration . . ."

In the very next paragraph, Miss Weeks established the immovable object:

"To the doctor, the first duty is that of obedience—absolute fidelity to his orders, even if the necessity of the prescribed measure is not apparent to you. You have no responsibility beyond that of faithfully carrying out the directives received."

The nurse, wrote Miss Weeks, was the "connecting link" between the doctor and the patient, responsible to the one and for the other. This point of view was so widely disseminated as to be virtually a trade secret among graduates of the established schools of nursing. This is what it meant to be professional. To be the understanding link between the doctor and the patient, and to know how to be that link unobtrusively, was nursing ethics. ■

what she is doing, and yet she must be completely subservient to doctors. Today the nurse finds herself subservient not only to doctors, but to all the nondoctors who surround him.

Today's dilemma in nursing had its chaotic beginning with the expansion of the armed services in 1940. It became evident early in the expansion that there were not going to be enough nurses to serve both military and civilian needs, and both areas began to water down the quality of nursing service.

The attitude toward the value of the professional nurse became discernible when the military services, while accepting graduate nurses, also accepted untrained civilian attendants under civil service to work side by side with the nurses on the wards. Pay for the professional nurse in the army, with the relative rank of an officer, was $70 per month. The civil service employe, untrained, many times uneducated, started his hospital attendant civil service career with a salary of $85 per month. Along with the relatively untrained enlisted man, he held equal status with the professional nurse, under the jurisdiction of the ward surgeon, who also functioned as his own head nurse.

While these uncoordinated nursing services were developing in the military, civilian hospitals were reaching out for nonprofessionals to fill the gaps left by nurses who had gone into the services. As a result, uncoordinated nursing services made up of practical nurses, aides, volunteers and others developed in civilian hospitals as well.

Professional nursing, despite its statements that it was the agency to unify all nursing activities, was concerned only with registered nurses and students of professional schools of nursing. Whatever all those other people were doing on hospital wards, the nursing profession would not concede that it was nursing.

All of this "stay-in-my-own-back-yard" attitude on the part of the nursing profession, however, is a natural development brought about by the "*stay*-in-your-own-back-yard" attitude of doctors and hospital administrators. It is a self-perpetuating cycle largely attributable to the fact that nurses have not seen fit or have not been permitted to enter the broad picture relating to the total nursing needs of an organization, whether hospital or military service.

Surely doctors and hospital administrators can see that this is not good. Lack of leadership on the part of nurses has led to duplication of efforts, ineffective training methods, ineffective utilization of highly skilled personnel, competition among personnel surrounding patients for the doctors' approval, bickering and low morale. Since everybody's business is nobody's business, the patient has been caught in the middle.

Our schools of nursing today are preparing bedside nurses who, eight hours after they remove their student insignia, become head nurses, instructors, even supervisors. This is an absolute necessity, but the girls have no concept of the requirement of management in nursing. They are not only unprepared, they are petrified! Petrified at the prospect of accepting the responsibilities entailed in patient care, especially when the doctors they encounter are unsympathetic and uncooperative and the nonprofessional worker on the ward, with administrative sanction, pays little attention to their directives.

Nursing educators are also in a dilemma, and the schools reflect it. Like the hospital administrator, the school director has pressure from all sides: pressure from doctors to develop nurses who can care for specialized heart and lung surgery cases; pressure from pediatricians who want nurses prepared especially to care for sick children; pressure to include operating room experience in the curriculum; pressure to take it out as unnecessary; pressure to include psychiatric experience, public health, and industrial subjects. Over and above the howl of the pressure groups come the wails of the hospital administrator and general medical and surgical practitioners, many of whom hold the purse strings to school operations, to "Give us more bedside nurses. We don't want these elegantly trained women!"

The greatest danger lies in a lack of understanding on the part of doctors, who have community influence greater than that exerted by nursing educators. Lack of understanding may result in cutting the three-year schools to produce the bedside nurse in two years, without giving equal attention to the need for nursing leadership.

Provision for only a two-year graduate, without prepared leaders in the profession, will merely compound the felony. Roughly 30 per cent of the graduate nurses deemed necessary on an annual basis should be prepared for leadership. This procedure should result in fewer personnel losses, in less duplication of effort, and in elimination of inefficiency. Doctors, hospital administrators, and nurses must realize this.

Is it not possible for the registered nurse to have, and to recognize, a legal helper of professional stature, to whom selected duties can be relegated without jeopardizing the welfare of the patient or losing control of the small portion of the medical world that is designated nursing service—a service that is, to them—as medicine is to doctors—a sacred trust?

State laws do not reflect current practices where nursing is concerned. This is adequately demonstrated by a revision in the laws of the state of Washington, which, as recently as 1956, changed its Revised Codes to allow nurses to administer drugs and treatment under direction of a licensed practitioner. "It shall not be a violation . . ." the revision states, "for a registered nurse, at or under the general direction of a licensed practitioner . . . to administer prescribed drugs, injections, inoculations, tests or treatment."

Whether nurses like it or not, whether doctors know it or not, or whether the public understands it or not, people other than registered nurses are currently doing these things. If graded structures and controls were instituted, there would be an outside chance that the nursing supervisor would be in more constant attendance with better prepared nursing practitioners giving the actual care to patients, and it should be much safer.

It is impractical and economically unsound to attempt to educate *all* the professional nursing personnel we need to a leadership level. Those applicants to nursing schools who have the potential for leadership in the field of nursing should be directed to schools which can, and will, instill leadership qualities in them from the date of entrance, even while they are learning the elements of nursing care which they will later teach and supervise.

Such a development will take time, of course. It will necessitate not only a change in attitude on the part of doctors and hospital administrators toward nursing leadership, it will require, to some extent, a change in the attitude of nursing leadership itself. It will probably require the development of more two-year schools with governmental and armed forces recognition

of the function of all nursing service personnel, and a unified control that will permit proper utilization of all categories of skilled personnel in medical installations in time of national emergencies.

It is not unrealistic to believe that more two-year schools can be developed to prepare safe, patient-oriented nursing personnel to give the nursing care required by our demanding population. The more advanced schools can then instill leadership attitudes in the minds of students from the outset of their education for the direction, teaching and supervision of nursing services. By this means, high school graduates of many abilities can be effectively, and safely, utilized in the nursing care of both military and civilian patients.

Teaching nursing executives to live and let other nurses live is the greatest challenge to modern nursing, for it is nurses' treatment of nurses—their failure to be fair and impartial to personnel under their jurisdiction—that is the greatest obstacle to meeting the personnel demands of the public for nursing service. It is the mark of poorly trained leaders.

But nursing leaders I have talked with see problems:

"It will necessitate changing the school curriculum. . . ."

But it is less expensive than living with a nursing shortage and a constant turnover of personnel.

"High school students want to be R.N.'s. What would be the title of the various categories of nursing personnel?"

These are details. There is little use to worry about the titles to be used until doctors, hospital administrators, and nursing leaders themselves can agree on a unified approach to the problem.

This will not come until there is some agreement on what total nursing service is, who is responsible for it, how many people are a part of it, and where we can find enough people to accomplish all aspects of it. ■

In Time of Emergency, Nursing Personnel Must Be Used for Nursing

WHEN is a practical nurse not a nurse? In time of war, when her services in nursing are most critically needed, she could be peeling potatoes or filing directives in quintuplicate.

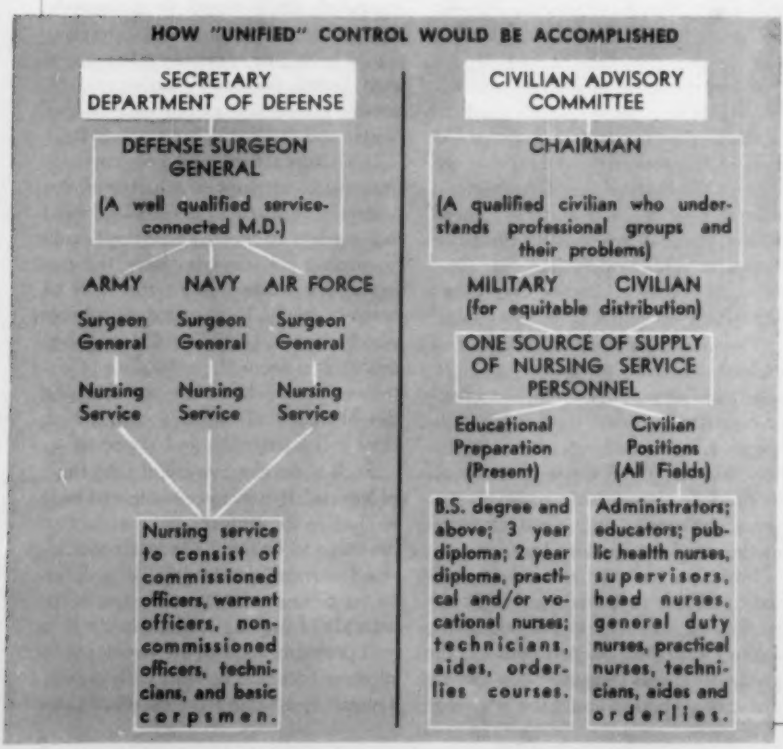
This situation, absurd as it is, results from the present setup of our military medical service organization which, in time of national emergency, gives the "military" authority to decide where enlisted or drafted personnel shall be placed. For example, women who enlist or are drafted into the service are subject to placement by nonmedical personnel administrators of the Womens Army Corps. Thus, practical nurses or hospital-trained attendants—even nursing personnel not eligible for commission as officers in the nurse corps—might or might not be utilized in hospitals, clinics or other medical installations. Their services could be completely lost to hospitals.

And there is nothing the army surgeon general can do about it. Under the present system, he has continuous jurisdiction only over the professional elements of the medical service: doctors, registered nurses, physical and occupational therapists, dietitians, and commissioned officers of the medical service corps. Despite a classification system designed to retain enlisted personnel in medical facilities, hospital-trained people are easily deflected to other work if the "military" so decrees. The surgeon general's staff relationship is such that he is not in direct contact with either Congress or the Secretary of Defense, to whom he might otherwise turn for help.

Civilian hospitals have little incentive to revise their own schools of nursing to produce more and better trained leaders and workers only to lose the workers in time of emergency to the military service where their training may not be put to proper use.

The accompanying diagram shows how essential nursing personnel could be unified to make sure that hospital people are used in hospitals in the event of a national emergency. If collegiate schools of nursing developed Reserve Officer Training Corps (R.O.T.C.) programs, leaders for all the services could be prepared for commissioned rank responsibilities in the same way that other branches of the armed forces train their officers.

A common roster with professional nurses actually trained for leadership in emergencies in any one of the services would provide a reservoir even more valuable than that maintained by the American Red Cross in the early 'Forties—the reservoir that made possible the rapid expansion required in World War II.



Train your own conference leaders

In this first article in a series on training supervisors the author tells where to find the best conference leaders, how they can be trained, and how to get the program off the ground

Leonard Nadler

THE group sat around the conference table, all eyes on the speaker. As he finished pointing out the need for clear lines of communication, the group broke into a roar. One member claimed the description of the communication process was all wrong. Another commented that his situation was different. Gradually, the "speaker" helped the group members to clarify their thoughts. An observer would have noted that the speaker was really a conference leader, and a good one.

An hour later the group broke up and its members returned to their jobs in the various parts of the hospital. The air had been cleared, and some new concepts explored. By no means were all the questions resolved. But the group (now individual employes) was on its way to a better understanding.

This is not daydreaming. Even as you read this, similar supervisory training conferences are being conducted in many hospitals in our country. These training groups need not be limited to large hospitals or to a multi-hospital system. All hospitals can have worth-while supervisory training conferences.

Most administrators recognize the need for training their supervisors. The problem is usually one of overcoming the "how" and "what." These are not insurmountable problems, and there have been some healthy experiences to show it can be done.

There are many places to which the administrator can send his supervisors for training. Experience has indicated, however, that the best training is done closest to the job. If supervisory training can be accomplished on the job, the benefits will be greater. Outside experts have their place. But what about the resources you have right in your hospital?

To plan for supervisory training, it might be well to begin with finding a training conference leader. Then, seek out the best place to hold the conferences. Notify all those who are to attend, and you are almost ready to hold your conferences.

The conference leader you are looking for is one who leads conferences, rather than teaches. He should know something of supervision, but need not be an expert. As a matter of fact, the expert can be a source of difficulty at this stage. Knowledge of the hospital culture is extremely important.

Two sources come to mind. You can either hire an expert or develop your own. Each approach has its advantages and limitations.

Let us first consider the outside expert. This assumes you have the money to hire the best. Since there is no qualified registry of such people, as one has with doctors, nurses and medical technologists, the quack is too often present on the scene.

Not all outside conference leaders are quacks. There are some excellent ones, if you think they can fill your need. Professional organizations can be of assistance in locating a qualified conference leader. The American Society of Training Directors is the leading national association, but by no means the only one. The American Hospital Association and the state associations might be a source for advice.

The growing need for training conference leaders, particularly in the area of supervision, has brought many of our colleges and universities into the field. The services offered by many of them include both on-campus and off-campus educational activities.

Let us proceed to explore the possibility of using one of your own hospital people to conduct these conferences. How would he measure up to the qualifications noted earlier?

(Continued on Next Page)

Leonard Nadler is chief of the training division in the bureau of personnel, Pennsylvania department of welfare. Advising hospital superintendents and other administrators on training is included in his duties. He held a similar position in New York for three years, serving as training supervisor in the personnel services division of the department of civil service. Mr. Nadler has a bachelor's degree in accounting and a master's degree in business education; he is completing work at Columbia University for his doctorate in educational administration.

You are looking for somebody who leads conferences, rather than teaches. This is a skill which can be acquired.

He should know something of supervision, but need not be an expert. If your hospital is functioning, you must have staff members who know quite a bit about supervision.

Knowledge of the hospital culture is extremely important. This should be the easiest qualification to find among your staff.

Finding a willing conference leader may be difficult, but it is not impossible. Our hospitals are staffed with specialists of many sorts, but few educational specialists prepared to lead conferences. Here is where the administrator can exhibit his knowledge of his people. The good conference leader may come from nursing, dietary, laboratory and even the business office.

Skill Must Be Learned

There is no easy set of rules to aid you in identifying the best conference leader from among your staff. In addition to the other qualifications, you want somebody familiar with more than his own niche in the hospital. He should be a supervisor, respected by his fellow supervisors. If he has all other qualities, it is likely that he may be weak on conference leadership. This is the skill which you must help him acquire. If you have the funds, he can be sent to learn conference leadership. There are opportunities like that provided by the National Training Laboratory, and there are workshops run by various professional organizations and other qualified groups.

If you are fortunate enough to be part of a multihospital system, it may be even easier. In New York State, for example, conference leaders for the mental hygiene hospital system are trained by the staff of the training division in the department of civil service. In Pennsylvania, all state owned hospitals under the department of welfare have had this opportunity made available to them by the training division in the department.

The small, single hospital unit need not feel left out. If money is scarce, and there can be little in the way of outside help, the conference leader still can be developed. For any sensitive person, there is ample literature that can help him sharpen up his conference technics!

The conference leader now has been chosen and is busy being trained, or training himself. This is the time for the administrator to look around and select the proper setting for the conferences.

One consideration is status. There might be a good room next to the steam plant where the fellows have lunch and play poker. But how does the rest of the hospital see this site? How would the ward supervisors feel about being invited to this room for their conferences?

If you have a school of nursing, one of the classrooms might look inviting. If so, just picture that 200 pound accountant squeezing into one of the chairs. Also, remember the earlier injunction against teaching? It would be a rare conference leader who could refrain from teaching if surrounded by the classroom atmosphere.

The dining room might prove to be the place; however, will this limit the hours of the conference? The dietary staff has a lot of preparation and cleaning up to do in addition to just serving hours.

If you are lucky enough to have an inner sanctum (commonly called a board room), this might serve. It certainly has status, but what will the board say?

Obviously, there is no pat answer to the question of the right room. The factors discussed previously should be taken into consideration. The traditions and rules of each hospital create additional factors that cannot be ignored.

Above all, remember that the training group is composed of adults. They want chairs they can sit in without developing backaches or being lulled to sleep. They want adequate light, particularly if the years have made things a bit duller than they used to be. During the conference, they want to be able to hear what is going on. Outside noises and movement can be serious distractions. It is the rare adult who does not smoke, so proximity to the operating room and similar sensitive areas must be considered. In many of our hospitals, wards are kept quite warm. This may be healthful for a patient, but it can be deadly for a conference.

The conference leader is going to need some equipment. A blackboard is most useful. If none is available, how about a pad of newsprint that can be taped to the wall? The pad and suitable crayons can be purchased inexpensively from any art supply store. An enterprising orderly once showed a group of sophisticated trainers how easy it is to make a flannelboard from a blanket, heavy paper, and sandpaper donated by maintenance. (See accompanying box.) A projector is not a necessity, but it might be useful. There is a wealth of filmed material that certainly can be helpful.

There is an adage of adult learning that "the mind can absorb only as much as the seat can take." Usually, one hour is the point at which your group will begin to squirm. However, two-hour sessions are more fruitful. To reconcile the two, arrange for a break. The coffee break is the usual, but any variation of refreshment can be helpful. Just watch your timing, for the group does a lot of healthy talking during the break that should be channeled back to the conference table.

All of us take surprises differently. Some welcome a surprise to break routine. Others freeze up when confronted with it unexpectedly.

Let the Group Help

The happy medium is to involve the training group in the development of the program. After it has been explained to them, enlist the aid of the members in locating the best room. Ask for suggestions as to refreshments during the break, and other housekeeping details. This is a good time to inform them once again that the objective is not to teach them supervision, but to provide a mechanism for sharing. Find out from them how the group can help in the sharing process.

When the day and time for the conferences have been selected, notify all concerned. Give them enough time to arrange for ward coverage, possible emergencies, and all the other contingencies they must keep in mind. (This is a learning experience that will be fed into the program at a later date.) The exact amount of time that people need to prepare for the conference is a personal factor. Don't get your conference off to a poor start by short notice.

Assuming that the opportunity to attend the conferences is open to all supervisors, what problems can you expect? The desirable size of a training group varies from 10 to 15. In small hospitals, this figure might have to be reduced to eight. If you have fewer supervisors than that, you might consider a study group rather than a conference. However, most of our hospitals will have at least eight supervisors.

Who is a supervisor? In general, it

is anybody who accomplishes his work by directing the efforts of others. On the ward, it would be at least the charge nurse, sometimes called a head nurse. Don't get involved in titles, as they can be misleading. At one time I have observed a group of head nurses who kept talking about supervisors. They spent several sessions talking about supervisors and wrangling over many minor points. It wasn't until some sessions had passed that one of the group asked, "Do you mean Supervisors or supervisors?" There were Supervising Nurses, and the group felt that only nurses in that title supervised! In other areas of the hospital, the distinction may be easier to make.

Frequently, doctors, psychologists, chaplains and other specialized personnel will ask to be included in the group. As they are not supervisors, it might be well to exclude them. However, many of them have proved to be valuable participants in the group. About the only generalization that can be made about excluding anybody is: Don't include a supervisor and the person he supervises in the same group.

Covering all shifts usually raises a problem. Some hospitals meet this by giving compensatory time off to those supervisors who attend on days off or when they are normally not on duty. One hospital tried to solve this by having the conference leader conduct sessions at different times of the day and night. This wreaked havoc with the normal work schedule of the conference leader. Usually, there are too few supervisors on th. second and third tours to warrant a special group. On the other hand, many advantages can be found in having personnel from various shifts present when discussing problems. Few problems belong to one shift only. Many are the problems that one shift visits on another.

Should every supervisor be forced to attend? Compulsion is considered undesirable. However, what should an administrator do about a supervisor who refuses to attend regular staff conferences? Would the average administrator countenance the boycotting of the regular conferences? Isn't attendance at these conferences part of the supervisory responsibility for which a pay check is given? The training conferences can be likened to the regular staff conferences. They are part of the normal working situation. This approach can lessen the stigma that might arise in the form of "Only the deadheads need the training anyhow!" If attendance at the training sessions is part of the job, the training group and the entire hospital probably will be more receptive.

Content of First Program

This "first" program in supervisory training should be considered merely exploratory. It is meant to provide a common experience for supervisors who already share the bond of working in the same hospital. For some, the conferences will introduce a new vocabulary of supervisory jargon with which they have previously not been familiar.

There are those who say that training should start with a survey of needs. This is fine if the group can identify its needs. For those who have been supervising without knowing the "why" and "how," this might prove difficult. The experience of the training conferences may enable them to respond more intelligently to the survey of needs, which would come later.

Up to this point, nothing has been said about specific subject matter. Actually, this would take a book and many books have been written. In future articles, we shall explore some of the usual content of supervisory training with particular emphasis on hospital training experiences. ■

A FLANNELBOARD IS A USEFUL VISUAL AID: HERE'S THE WAY TO GO ABOUT MAKING ONE

THE flannelboard is an effective visual aid. Its particular value is to show, by the use of prepared words or sketches, the progressive movement of material or the development of an idea. If your budget won't permit you to buy one of the good commercial ones on the market (about $40), do not despair. Almost every hospital can make one with a little ingenuity and a few economical supplies.

To construct a flannelboard you will need: a blanket; a frame or rigid surface that can be slightly tilted, and sandpaper (the coarser the better).

The need for other supplies depends on how the board will be used. Crayons, cardboard or poster stock, and like items probably will be found close at hand.

Any blanket with a nap will do. Color is not too important, but, if you do have a choice, relate the color of the blanket to the material to be displayed. For example, if the material you will display is white, you should try to obtain a dark blanket. The size of your group, the lighting in the room, and how the group will sit are factors to consider.

The blanket should be draped fairly taut on a rigid frame or surface. (Being too taut also can be a problem.) A rolling blackboard is probably one of the best devices for this purpose. However, there are many other pieces of equipment around the hospital that could be made to serve as well, after a few trials. A tilted surface is best because it increases the tendency of the display material to adhere.

For placing the material on the blanket, the sandpaper comes in handy. Small pieces will do. The material to be displayed should be glued, stapled or taped to the sandpaper. Then, place the material on the blanket, with the sandpaper against the blanket. A slight downward movement will be found helpful.

There you have it: a homemade flannelboard with materials readily available in most hospitals.

Mind those telephone manners!

Right: Irene Jung, a service consultant for the Ohio Bell Telephone Company, coaches professional nurses, aides, and interns in proper technic for using telephone.

Pictures from Ohio Bell Magazine, published by The Ohio Bell Telephone Company

THE telephone, one of the most important implements in a hospital, can be a help or a hazard, depending on how it is used. To teach employes at Mt. Sinai Hospital in Cleveland the proper way to use the telephone, the chief switchboard operator called in a service consultant from Ohio Bell Telephone Company. The consultant, Irene Jung, gave lectures and dispensed printed information to doctors, interns, nurses and aides, dietitians, secretaries, technicians and others. Among the correct telephone technics they learned were those illustrated on these pages.

Left: Transfer calls properly. Nurse at station explains to caller, flashes operator very slowly. She keeps list of frequently called numbers on wall to save time, trouble. Above: If you must l e a v e line, explain absence. Party may prefer to call back. On your return to telephone, thank the caller for waiting.

Left: Dial accurately. This is of particular importance in the emergency department. Identify yourself on all calls. Always be courteous, tactful.

Left: Answer phone promptly; speak directly into transmitter. Repeat numbers to ensure accuracy. In central supply, pharmacy or laboratory this can be most important. Always remember to keep telephone promises.

Left: When placing call, be ready to talk. Intern waits at speaker for call he placed, will pick it up on hall telephone. When leaving your office, tell where and what time you can be reached.

ABOUT PEOPLE

Administrators


E. L. Harmon, M.D.

Dr. Edwin L. Harmon, director of Grasslands Hospital, Valhalla, N.Y., for 19 years, has been appointed medical director of Michigan Blue Cross, effective October 1. Dr. Harmon will succeed **Dr. Brooker L. Masters,** who resigned July 1 to return to private practice. Dr. Harmon is a trustee of the American Hospital Association and a fellow of the American College of Hospital Administrators. Prior to his tenure at Grasslands Hospital, he was assistant director of University Hospital in Cleveland for nine years.


Margaret E. Peters

Margaret E. Peters has been appointed administrator of the Institute of Physical Medicine and Rehabilitation and assistant administrator of University Hospital, New York. Miss Peters formerly was administrative assistant at Grasslands Hospital, Valhalla, N.Y. She received her degree in hospital administration at Yale University, and was awarded the Otho Ball Memorial Scholarship by the American College of Hospital Administrators for an extended residency at Grasslands Hospital in 1957.

Sister Marguerite de Montmartre, administrator of Lewis Memorial Maternity Hospital, Chicago, for six years, has returned to the Montreal headquarters of her order, the Sisters of Charity of Providence, for reassignment. Sister Marguerite had been on the hospital staff for 28 years, and during that time instituted the hospital's social service work, founded the doctors' medical library, and started a monthly bulletin. Her successor will be Sister Rose of the Precious Blood, administrator of St. Elizabeth's Hospital, Yakima, Wash.

David C. Reynolds, administrator of Madison General Hospital, Madison, Wis., for 11 years, has resigned.

Kenneth S. Meredith, administrator of Cafaro Memorial Hospital, Youngstown, Ohio, has been appointed administrator of Bedford County Memorial Hospital, Everett, Pa. He succeeds **Thomas Paden,** who resigned to become administrator of Citizens General Hospital, New Kensington, Pa.

Stuart Marylander, who has been administrative assistant in charge of personnel at Cedars of Lebanon Hospital, Los Angeles, for the last year, has been named assistant administrative director. In this newly created position, Mr. Marylander will be responsible for supervision of specific hospital departments and will coordinate special major projects. He holds a bachelor's degree in hospital administration and a master's degree in public health from University of California.

Donald H. Pound has been named director of Edward W. Sparrow Hospital, Lansing, Mich. Mr. Pound, a faculty member at Michigan State University, has been acting director since the resignation of **Glenn Fausey.**


Frederick Grubel

Frederick Grubel, associate director of Maimonides Hospital, Brooklyn, N.Y., has been appointed associate director of Montefiore Hospital, New York. He will be in charge of Montefiore's fiscal affairs. Before going to Maimonides in 1951, Mr. Grubel was assistant director of Beth Israel Hospital, New York, assistant budget director of the Federation of Jewish Philanthropies of New York, and director of finance and accounts of the American Joint Distribution Committee. He is a member of the A.C.H.A., and holds both law and business administration degrees. He also is a certified public accountant.

Walter W. Ellis has been appointed administrator of Alexander Linn Memorial Hospital, Sussex, N.J. He formerly was administrator of Memorial Community Hospital in Edgerton, Wis. Mr. Ellis will succeed **Helen Coates,** who has retired.

John H. Reitmann has been appointed administrator of Hastings State Hospital, Hastings, Minn.


William B. Calvin

William B. Calvin has been appointed administrator of Memorial Hospital of Roxborough, Philadelphia, succeeding **W. Allen Walton.** Mr. Calvin has been assistant director of Mountainside Hospital in Montclair and Glen Ridge, N.J., since 1957. Prior to that time he was assistant director of Muhlenberg Hospital, Plainfield, N.J. He received his hospital administration degree from Northwestern University. Mr. Calvin is a member of the American College of Hospital Administrators.


William Slabodnick

William Slabodnick has resigned as assistant administrator of Massillon City Hospital, Massillion, Ohio, to become administrator of Fisher-Titus Memorial Hospital, Norwalk, Ohio. Mr. Slabodnick has been associated with the Massillon hospital since 1948 as chief pharmacist and as assistant administrator. He is a graduate of the hospital administration program at the University of Chicago, and received his pharmacy degree from Massachusetts College of Pharmacy.

Francis M. Coe, assistant director of Elizabeth General Hospital, Elizabeth, N. J., for four and one-half years, has been named director of Babies Hospital, a unit of the United Hospitals of Newark, N. J. Mr. Coe is a graduate of Columbia University.

Thomas W. Fourqurean, administrator of Brackenridge Hospital, Austin, Tex., for five years, has been appointed associate administrator of Methodist Hospital, Houston. Mr. Fourqurean is a member of the American College of Hospital Administrators.

Charles H. Frenzel has been named superintendent of Duke Hospital, Durham, N. C. Mr. Frenzel has been assistant superintendent of the hospital since 1956.

(*Continued on Page* 202)

Observations in this research study suggest a basic dilemma that has emerged as hospitals have grown more complex:

The System May Come Ahead of the Patient

Howard E. Wooden

IN THE modern general hospital, the principal problems which confront personnel, medical staff, and administration are manifested in the form of numerous and weighty crises. What is all too often overlooked is the fact that hospital conflicts are simply special cases of the broader conflicts which characterize modern society as a whole. These are conflicts which cannot be pigeonholed, for they are interrelated and interdependent. When an attempt is made to disentangle them, they tend always to relate back to one misunderstanding, one most basic dilemma: our bifocalistic approach to understanding human behavior and the role of the individual in modern living — that is, our tendency to glorify the the individual but at the same time to evaluate the individual in terms of group standards.

Thus the hospital patient as an individual has definite, personalized needs which must be met in giving him care. Yet the traditions and routines which are imposed often detract from such an all-inclusive, patient-centered care program.

The physician, provided he has been thoroughly trained and is ethical in his practice of medicine, is assumed to possess more knowledge of the medical needs of his patient than anyone else, yet many times between him and the patient an inflexible system has been built which acutely curtails his establishing or executing a total program of care.

The nurse, in whose hands the patient is placed for 24 hours a day, is often so subject to pressing rules and regulations imposed by administrative and medical staff traditions that, even when she is capable and desirous of applying judgment, her hands are tied.

These situations, and dozens more like them, make for serious frustration

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Howard E. Wooden is a graduate of the Johns Hopkins University, Baltimore, where he also took a master's degree in history in 1948. For the next three years he was in Athens, Greece, under a Fulbright grant, teaching at Athens College. He returned to the United States in 1953 and accepted an administrative appointment at St. Mary's Hospital, Evansville, Ind., where he has been ever since. At present, Mr. Wooden is principal investigator for Research Project W-44, aimed at determining how well hospitals are meeting the total needs of their patients as individuals. This Public Health Service Project began in February 1956; this article is the first published report of the study's findings.

and inefficiency of operation and suggest the ever-growing need for a careful blending of the talents of all concerned so that justice to the objective cause, that is, the patient, may be appropriately effected.

However, when such predicaments are recognized, as they sometimes are, solutions are invariably sought in terms of establishing more rules and regulations. Without ever coming to grips with the basic issue, this approach merely introduces additional deceiving complexity into the system through the transfer of error from one corner to another. In the final analysis, it is the patient who suffers.

As one aspect of Research Project W-44, an analysis of critical incidents in many hospitals was conducted which has led to identification of certain major dilemmas in modern hospital practice. The principal forms which these various dilemmas tend to take in the routine operation of the general hospital are described here.

Discrepancy Between Purpose as Theoretically Expressed and Purpose as Applied Within the Hospital

While the purpose of the hospital may be clearly defined on paper, definition of purpose is frequently inadequate or not well understood.

As a social institution, the hospital is obligated to interpret the health needs of the community and to meet the needs for those who become patients. So expressed, the purpose can be found in the by-laws of possibly every hospital in the country and is included in all the public addresses delivered by hospital administrators and their public relations officials in an endeavor to gain community good will and support.

Yet it is questionable how fully the stated purpose of the hospital is actually comprehended by those directly engaged in hospital activity.

Fundamentally the purpose of the hospital is the patient, and it seems reasonable that the patient and his needs, as determined by appropriate scientific considerations, should constitute the ultimate authority in the hospital. But too often secondary issues creep into the picture which in time tend to control and overshadow the ultimate purpose and create a confusion of objectives.

For example, it is not uncommon for hospital administration to acknowledge that its principal function is to serve the doctor, who, in turn, will then be better equipped to meet the patient's needs. While this approach is effective in maintaining a high hospital census and may thereby financially enable the hospital to accomplish much which it would otherwise be unable to do, it nonetheless goes directly counter to the primacy of purpose by disastrously splitting allegiance.

The difference between a hospital and a business should be kept in mind: While the primary objective of a business is profit-making, that of the hospital is service in the form of *patient care*. Quite legitimately, business policy must be determined in terms of profit. At the same time, the client in business must, as a means to an end, be satisfied and is therefore the point around which much policy planning is oriented. But the client is *not* the ultimate objective of the business.

In the hospital, on the other hand, the client *is* the reason for being.

This is an odd paradox, for while in business it is often proclaimed that "the customer is always right," in the hospital the client is rarely if ever regarded as right. Yet the client — that is, the patient — is the purpose of the hospital!

How many people in the hospital can actually define what they mean by patient care?

How many of them understand that providing patient care really depends on a clear and precise knowledge of the individual bedded down in Room 650, and a clear and precise knowledge of the different needs of the different individual in Room 651?

How often is patient care based on a knowledge of human psychology, of the influence of environmental pressures on personality and personality development, of social and economic factors in relation to human behavior?

It is all well and good to say the hospital's mission is to provide patient care, but saying this and accomplishing the mission by understanding what it actually means in each individual case are two entirely different things.

How many physicians have come to understand the purpose of the hospital in these broader terms? How many contribute to the purpose in those terms?

How many understand that accomplishing the purpose means getting to know the individual patient and the many problems — psychological, social, economic and spiritual, as well as medical — which confront that patient?

How many nurses, technicians or administrators take these factors into positive consideration in the course of performing their respective duties?

How many physicians treat the patient, rather than the disease?

How many patient records bear notations about the whole patient?

How many times will the patient's history include references to social or psychological aspects as well as purely physical ones?

There is, of course, a limit to what the doctor, as an individual himself, can be expected to do, and perhaps time and a pressing schedule prevent him from recording such notes on the history.

But how many times does the doctor even bear these issues in mind when treating the patient?

A consideration of such questions points up the discrepancy between the clearly written purpose and the extent to which that purpose is understood and practiced.

Complexity Within the Hospital Tending to Produce an Environment in Which Concern for Operational Function Exceeds Concern for Patients

Assuming that the objective of the hospital is well defined and understood, functional application of this objective is often obstructed by factors which have come into being as the institution has developed. In other words, the more all-inclusive in purpose the institution becomes, the more strained and complex the institutional setting becomes — with resultantly less achieved in terms of its original objective.

Considering the relation between providing care and the state of operational complexity, there tends to be some critical point, yet undefined, beyond which the extent of achieving the original care objective varies inversely with the degree of complexity of operation — a point of diminishing returns.

It would not be uncommon to find, for example, that the laundry of a hospital has come to be as big and complex as any other laundry in town. In the operation of such a laundry, the hospital experiences all the problems and strains of personnel relations, equipment maintenance, costs, meeting deadlines and providing service, which are faced by any commercial laundry. Yet the successful management of a laundry certainly is in itself not the purpose of the hospital.

The same thing is true of any auxiliary function found in the hospital. That the laundry and other auxiliary services are important goes without saying. Nonetheless, hospitals did not come into being and do not function for the purpose of operating such units, even though hospitals face the need for so doing in order that their final goals of patient care may be reached.

This situation poses a real dilemma, for with such complexities and additional systems introduced, the goal of the hospital is inevitably neglected as hospital management becomes preoccupied with routine crises and with the need for problem-solving in realms other than those dealing with direct patient care.

Tradition and Conflicting Social Ideologies Within Hospital Organization and Their Impact on Patient Care

A third dilemma is brought on by the conflict between component elements within organizational policy. Policy is imposed in order to make an organization work. In the hospital, policy seems to consist largely of routines and procedures which have to a marked degree been handed down by tradition.

Hospital policy, however, is not entirely tradition. In part it has followed certain socio-economic and educational currents which move on ever-changingly and which are now embodied in most up-to-date personnel policies—for example, in time-work schedules, in recruitment, and in salaries.

The validity of social changes such as these which are reflected in policy is not to be questioned from the standpoint of the well-being of hospital personnel. Yet a review of these facets of policy suggests that neither the time-honored routines nor the rightly liberal hospital personnel policies are necessarily in the best interest of actual care. In other words, routinized baths, temperature checks, enemas, and other nursing routines may simply represent in many cases blind and unnecessary tradition, detracting from patient care. Admitting procedures that are sometimes rude and inconsiderate of the patient, financial procedures, endless streams of requisitions and other financial controls structured between the nursing station and central service, pharmacy, dietary and the paramedical services are often viewed by personnel as attacks on the professional values and judgments of the people concerned with care and may thereby tend to depress the level of patient care.

Furthermore, while hospital personnel needs and deserves ample free time and numerous fringe benefits such as rest periods, coffee breaks, regular scheduled work hours

and work loads, and a liberal vacation plan, such practices do not readily mesh with the actual needs of patients.

This is a major dilemma in hospital operation, since it clearly displays two conflicting phases of the same ideology —the needs of the patient and the needs of the personnel, both of which must be met.

Persistence of Hierarchy in the Organizational Structure of the Hospital and Its Effect on Hospital Services

Whereas modern administrative research on the one hand and the existence of specialization in the hospital field on the other hand suggest the advantage for authority based on knowledge, hospital administration seems to be undergoing a centralization of power in which authority of position, rather than authority of knowledge, dictates policy and operational patterns. The claim of hospital administration today is that total patient care is achieved through the interplay of the knowledge and talents of a variety of groups which through their joint efforts can identify and meet the needs of patients by working together toward the one common goal.

To be put into action, this claim would demand that hospital administration function as a coordinating mechanism among the various services within the hospital.

Actual trends in hospital administration, however, suggest an entirely different understanding and practice; while group participation in establishing policy is outwardly welcomed, its merits are actually not well understood, and it is therefore viewed suspiciously as a potential threat to the hierarchial framework of hospital organization. The dominant determinants of hospital policy and practice continue to rest more upon tradition, financial demands, and the preservation of the group—be it professional or administrative—rather than upon the individualizing of patient needs.

The best and most valid evidence of this dilemma is the degree to which systematization in the hospital takes the form of excessive and often blind routines and procedures, arbitrary action, and orthodox decision-making. Above all looms the budget, which, more than actual purpose, determines policy and the extent to which purposeful needs are planned. The alternative of viewing the budget as a function of need is often overlooked.

The ever-increasing need for people to work in the spirit of self-sacrificing dedication is recognized by hospital people, who understand that the prevailing system of values in modern living tends not to prepare many such people. Yet frequently when such an individual is found, whether he be on the professional or nonprofessional level, physician or employe, he tends to be denied any degree of the autonomy necessary for his own psychological satisfaction. Either he isn't recognized or he's distrusted, and, perhaps unconsciously, an effort is made to force him into the common mold. The ponderous machinery of systematization and inflexible policies are permitted to interpose themselves between him and the service which he is charged to perform, so that he ends up frustrated and often unable to accomplish his mission. Rules, regulations, policies, procedures, do's, don'ts, hows and how-nots inhibit him, barring him from accomplishing the very thing he wants to do, is often capable of doing, and was employed to do!

Failure of the Hospital Administrator to Serve as Creative Leader and Coordinator of Human Activities

A principal need of contemporary social institutions is the correlation of purpose and performance. It is the function of the administrator, as leader and coordinator, to establish a design which will accomplish this in the hospital. Specifically, it is the function of the administrator to correlate all the elements of the hospital—the medical staff, personnel, facilities and community demands—so that they may be focused most effectively on the patient and patient needs.

But a dilemma results from the administrator's preoccupation with the numerous complexities within the hospital, with resultant neglect—albeit unintentional—of the coordination of activities. This means that effective functional organization, which sets its primary goal in advance of any distraction or interference, is sadly wanting. The most striking evidence of this is the neglect on the part of administration to see the patient as an integral part of organizational design.

A second aspect of the administrative dilemma stems from the narrow training and experience of the administrator. Though the task needed most of him is the coordination of activities, which deals essentially with human needs, he generally is neither trained nor learned in the field of human behavior:

Does the hospital administrator understand human personality?

Does he understand the effect of childhood experiences and adult pressures on the development of the human personality?

Is he fully cognizant of the role played by environment on people?

Does he understand about the learning process?

Does he know something about the importance of child care and its effect on the emotional health of the infant or growing child?

Does he see how policy, his policy, might exert serious influence on the patient for good or bad?

Does he see that his organization chart should be so composed that there is no obstacle whatsoever between the patient and the efforts of the medical staff or personnel?

Does he realize that the patients' needs change and that his organization chart, which is only a scheme on paper for meeting these needs, is therefore true only for a given moment and must change and undergo adjustments constantly as the needs of people—both doctors and personnel as well as patients—change?

Without that breadth and objectivity of outlook the administrative function cannot be performed. Too often the administrator is satisfied to play the role of the autocrat, or of the public relations man, or of the committee man.

If autocratically inclined he sees his duty as one of making and executing rules and regulations in accordance with inflexible policy.

If public relations conscious, he will tend to devote his energies to greeting outsiders graciously, and wandering through the building telling employes of the great jobs they are doing, and grasping at every opportunity to speak publicly about his hospital, altogether misunderstanding human relations and the obligation which the hospital has to the community.

If caught within the spell of the commonly misunderstood notions of group dynamics and "teamwork," which too often implies compromise with principle and blind conformity to mediocre standards, he will tend to play the role of a committee man, surrounding himself with other committee members, all of whom he must consult on all matters before coming to a decision, thus demonstrating decisively the evidence of indecision.

Efforts of this sort, while widespread in popularity, at most simply skirt the periphery of the problem of leadership and coordination but never drive directly toward its core. Too much channeling and over-systematization and too little constructive imagination and sincere dedication are at the basis of the predicament. The need to evaluate the hospital's purpose and performance and design organization so that purpose and performance coincide rests heavily on the shoulders of the administrator. When this is not accomplished the charge of inadequacy in administrative leadership and coordination seems justifiable.

The Impact of Specialization on Total Care

Another dilemma is the inevitable conflict between policy and care on the one hand and specialization on the other. Throughout the centuries hospitals have developed rigid policies in a large measure because of the variety and delicate nature of the services offered. It is difficult to imagine any social agency having more policies and procedures than one finds in the hospital, and difficult to imagine any agency in which specialization and "expertise" play more important roles.

In the hospital one hears talk of the specialized needs of patients. The doctor is foremost a specialist. The professional personnel in their own respective realms are becoming more and more specialistic—pharmacists, therapists, nurses, technicians, engineers. Finally, there is specialized equipment, effective performance from which depends on the knowledge and technical skills of specialists thoroughly trained and qualified to handle such equipment and perform such technical procedures.

These are all areas of specialization largely peculiar to the hospital, and at this point a dilemma is again disclosed. The specialist feels himself qualified, and perhaps rightly so, to know the answers to the problems within his province. He wants autonomy and no doubt needs a degree of autonomy for the success of his job, both from a technical and psychological standpoint.

Yet when his thinking conflicts with the thinking of the expert in another specialty, there is contention. Almost invariably, when the thinking of a specialized group of experts encounters opposing established policy, there is even greater contention, reflecting on care. Furthermore, the more specialized the approach to care becomes, the more "spotty" that care tends to become—that is, the more concentrated the approach tends to become in certain aspects and the more diluted in other aspects. The whole patient is then dismembered and the part patient becomes the point of departure.

Impact of Legal Misinformation and Fear of Liability in Patient Care

In the midst of the numerous complexities in modern hospital practice, there is an air of anxiety associated with the lack of a clear determination as to what precisely, in the legal sense, constitutes the practice of medicine. As a consequence, there has come into being a body of misinformation, confusion and half-truth, which, when coupled with rigid hospital policy and exaggerated professional ethics, has limited the ability of the administration to bring hospital resources quickly and effectively to bear upon patient needs. There has also been a tendency for many groups, particularly of professional personnel, to narrow their responsibility, to restrict their use of judgment in de-

The Challenge for Hospital Administration

The great challenge for hospital administration seems to be the acceptance of new ideas. It must invent and devise and apply intelligent judgment and a great deal of creative imagination.

It must not seek self-vindication by complacently accepting its accomplishments in the terms of the cliché, "We're doing our best under the circumstances." Nor should it assert itself through more rules and regulations in the hope of somewhat improving the current state of affairs; this approach amounts only to redistributing rather than eliminating error, with the resultant danger of multiplying the dilemmas which already exist.

The investigators on this project feel that any step toward shaping the hospital which is truly functional and patient-centered must first be preceded by recognition and acknowledgment of the stresses and strains manifest in current hospital operation. It is within these dilemmas themselves that a likely solution is to be sought.

cision-making, and, in the course of so doing, to rationalize in terms of the fear of legal liability.

Concurrently, various professional groups have become somewhat estranged from one another because of claimed professional values which tend to inhibit their cooperation in the job to be done. Divergent views on the privacy of medical records, the administering of I.V.'s by nurses, and the conditions under which patients may be admitted to the hospital and by whom are examples of this.

In many hospitals, for example, a request by a patient, employe or visitor for an aspirin to relieve a headache will be automatically denied unless the aspirin is ordered formally by a physician. The refusal is justified on the basis that the administering of any drug by a nurse may be construed as the practice of medicine.

At the same time, many hospitals sell aspirin in quantity without a prescription and without fear of any legal implications. This inconsistency is deemed acceptable, since the one course is viewed as administering by professional prescription while the other is a purely voluntary act on the part of the purchaser. This is one of many similar situations representing an attitude on the part of nurses which probably devolves from rigid limitations placed upon the nursing profession over many years.

The inconsistency is demonstrated further by the degree to which the physician depends on the nurse to diagnose emergency admissions. On the basis of her diagnosis, which, quite often, is reported to the physician by telephone, the physician freely prescribes treatment without first seeing the patient!

Another example of inconsistency often occurs in connection with the admission of critically ill patients who arrive at the hospital without a physician's order for admission. In such cases the patient may be detained in the admitting area for an extended period of time in order to meet paperwork demands, while the admitting officer or nurse attempts to obtain orders from a physician before putting the patient to bed. Neither the admitting officer nor the nurse feel they have the authority or the right to exercise judgment and provide a bed for the patient. The excuse given is the "legal angle."

In most such cases hospital rules, completely independent of any legal demands, are at the basis of the confusion. While becoming professionalized, the nurse has reached a point in her thinking where she ordinarily will not question the validity of procedures; she looks upon them as proper and in accordance with established policy and fears possible legal implications that might arise if she did otherwise. Even though the nurse is considered a professionally trained person today, and even though her change in status, which has been accompanied by a marked elevation in formal educational standards, has equipped her to perform numerous procedures which hitherto were carried out only by the physician, there remains an unwillingness on the part of administration and medical staff to recognize the ability of the nurse to make judgmental decisions.

The same seems true, but to a lesser degree, of other groups in the hospital which in recent years have begun to assume professional status. The result is that while professionalization reaches toward improved service, its purpose is often defeated by fractionalization, narrowing responsibility, and inflexibility in the system—all of which are frequently confused with legal misinformation.

At University Hospital, Ann Arbor, Mich., live animals brighten long days for young patients. Animals have definite therapeutic value for children, hospital officials say.

United Press International Photograph.

Animals help them get well

CHILDREN who are patients at University Hospital, Ann Arbor, Mich., find a complete educational and recreational program for their benefit. A hospital school, located on the eighth and ninth floors, is attended by approximately 5000 youngsters and teen-agers during a year. The education program begins with the nursery age group and continues through high school, and also provides commercial and prevocational training for those who desire it. The school is under the leadership of the hospital administration and its staff consists of a director, an assistant, and 28 special education teachers. In addition to school work, there is a planned recreation program for teen-agers and children; a librarian services all the wards. While the obvious function of the school is to allow children to continue their education, the program also accomplishes much in the way of therapy. The school provides a touch of the familiar in a world that may be strange and

This article was prepared by Dr. A. C. Kerlikowske, director, University Hospital, Ann Arbor, Mich.; Mildred Walton, director of the University Hospital School, and Richard J. Hinds, an assistant director of University Hospital.

PETS OVERCOME CHILDREN'S FEAR OF HOSPITAL

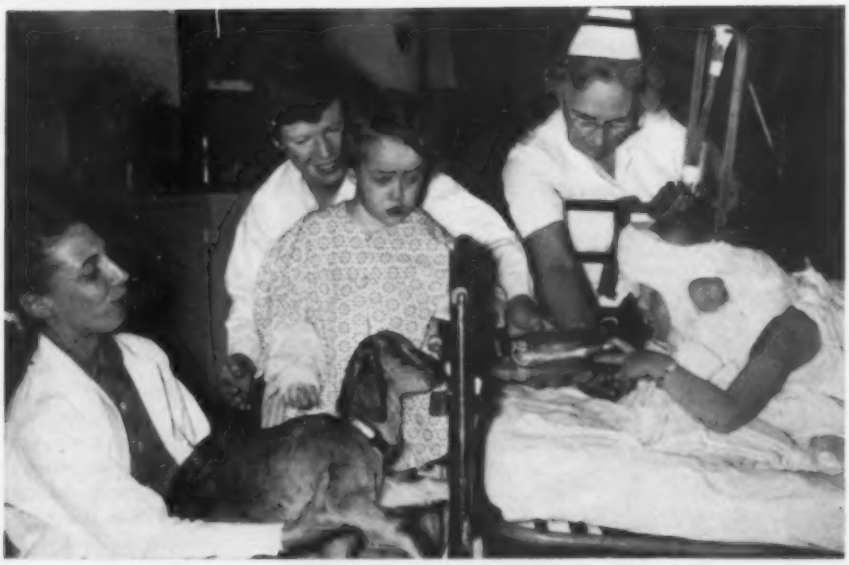
frightening. Among the most attractive and unusual features available to interest the young patients are live animals. The school's menagerie presently consists of two birds, six rabbits, two coati mundis, a white mouse, a guinea pig, and a deodorized skunk. The animal program was initiated in 1945 in an effort to conquer "hospitalitis," the melancholy to which young patients seem especially susceptible. This therapy proved extremely successful, and the hospital school has enlarged its pet facilities.

Right: Children are fascinated by high-wire act of coati mundis, South American members of raccoon family. Below: Boy is feeding a three-week-old goat which visited at hospital.

Along with its permanent animal guests, the school often is host to visitors, which recently included a dog, two puppies, a baby duck, and a three-week-old goat. Although it is not practical to keep these animals indefinitely, they arouse much excitement while they are present. All animals except the coati mundis are housed in galvanized cages constructed on wheels in units of six so that they can be easily moved from place to place. The coati mundis, South American members of the raccoon family, occupy a special floor-to-ceiling cage in the school workshop. Children learn to care for the pets and realize, almost unconsciously, the value of cleanliness and proper nutrition in their own lives.

The school's prime concern, however, is to promote a love for, and interest in, the pets. Parents are most enthusiastic about the school, and the animal program in particular, and often a child is allowed to adopt one of the baby animals born in the hospital.

The animals also are used in the unit study teaching method which the hospital school employs. Under this plan, the children concentrate their efforts on one subject, for example communication, for a specific length of time. Arithmetic, spelling, reading, social studies, science and arts and crafts are all related to the main theme. When South America is the topic, the coati mundis always stimulate much interest, At Easter, baby chicks and baby ducks are brought into the hospital. Another popular springtime study

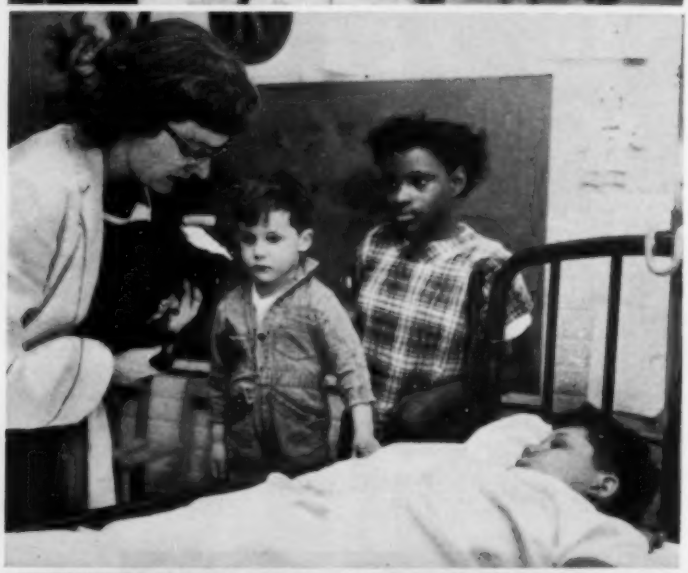


unit involves baby snakes. Although the animals are housed on the ninth floor, ward-bound patients are not deprived of their company. Often when a teacher goes to the wards with school work and arts and crafts materials a white bunny acts as custodian of the texts and crayons. Turtles and tropical fish have proved to be interesting companions for long-term and immobile patients, and as the children learn how to set up an aquarium, they spend many hours observing its lively occupants.

Other activities in the school's program include planting and tending window boxes, and churning butter during a dairy study unit. The children may study nurses, doctors and the hospital itself in another unit, which has proved most successful in alleviating fears. Holidays are celebrated with parties. Elementary school children who can walk or who can be moved in bed or in a wheel chair are taken to the

Left, above: A giant black hare goes for a ride in a baby buggy skippered by one of the children .Animals also are used in University Hospital's school courses for youngsters. Left: A friendly puppy is able to perk up a long hospital stay for this youngster.

Above: The visiting goat is fed again, this time by a ward-bound child. Teachers visit bedridden children with arts and crafts materials, school lessons, and even animals.



Kiwanis supported play-school room or the Galen supported craft shop for two hours of free play and school work each morning. From 2 until 4 o'clock in the afternoon, they again take part in an activity program. At the same time, high school students attend school in the eighth floor classrooms. Ward teachers take carts of materials to children who can't be moved, and another teacher works solely with youngsters in the isolation unit. School is officially over in June, and all activities move to the sun porches adjoining the play-school room and the workshop. These are appropriately equipped for children of varying ages. Although the education and recreation program of the school adds something to hospital costs, its demonstrated therapeutic values make it well worth while, according to Dr. Kerlikowske.

He stated: "Along with the added knowledge gained by the child goes a definite therapeutic value which is both physical and psychological. It is particularly evident in the child with the long drawn out illness who previously has been hospitalized in the more conventional hospital setting. The child arrives withdrawn and depressed from the cumulative effects of illness and isolation from usual childhood companions. After exposure to both the regular and the animal personnel of the hospital school, personality changes rapidly become evident. He resumes a child's usual outgoing personality and begins to socialize with other patients. With this change, medical progress seems to speed up."

Top picture: Tiny polio patient touches baby chicks. Children are taught to love and care for animals, which are housed on ninth floor of hospital. Center: A deodorized skunk is a permanent member of hospital's animal family. He's shy, though, and only the teacher can handle him. Staff of hospital school has director, assistant and 28 special education teachers. Ambulatory children and those who can be moved go to school on eighth, ninth floors. Bottom picture: Turtles and tropical fish provide many hours of entertainment for long-term and immobile patients. The children learn how to arrange their own aquarium. Some 5000 children and teen-agers attend classes, from nursery school to high school, at the University Hospital during a year.

Hospitals Shouldn't Look Like Night Clubs

A designer of night clubs, stage scenery, and showrooms who likes modern interior treatment still finds the trend toward the ultramodern in the construction of new hospitals "frightening" and thinks patients do, too. Here he tells the reasons for his views, and on the succeeding two pages, four representatives of the architectural and decorating fields discuss his thesis pro and con

John Sutton

I DESIGN night clubs. Also restaurants, showrooms, stage scenery, and homes. In these areas, the contemporary in architecture and interiors is prominent and in some—like night clubs—it is dominant. But I find it rather frightening to observe a trend in new hospital construction to outpace the night clubs in the race for the ultramodern look.

Let's Not Go Too Far

A swing away from the sedate, drab and institutional look of 50 years ago is fine, but are hospitals swinging too far the other direction into bizarre architecture and vivid, too-modern decor? From the point of view of a designer with a great deal of experience as a hospital patient, I think they are. Here are some of the reasons.

A hospital is costly to build and it must be constructed to last for many years. Certainly 50 or 75 years is not unreasonable to expect with the increased durability of materials and the new building technics. Even interiors have taken on longevity with the development of plastics in a wide range of colors that withstand wear and tear as fabrics, wall and floor coverings. But in this anticipated long usage, today's contemporary styling has an excellent chance of becoming freakish and outmoded, because we are in a period of rapid shift and change.

In earlier centuries architecture could look to staying in style for more than a hundred years, interior furnishings for about 50, and even wearing apparel didn't change basic styling oftener than 10 to 20 years. Nowadays building styles, interior styles, and clothing styles are being discarded almost as fast as they are created.

Into this kaleidoscope of change has come a vast program of hospital expansion. Unless care and restraint are exercised, today's modern hospital may turn out to be tomorrow's architectural horror.

Only Part of Problem

What today's new hospital will look like 30 or 50 years from now is only one side of the situation. What does today's new hospital look like *today* to patients and their families? That's an important aspect as we consider the impact of ultra-modern decor on the human element.

In the early 1930's the Chrysler Building, Waldorf-Astoria Hotel and the first of the Radio City group were built. The former two constructions were too "moderne" and now after 25 years have a very dated look. Meanwhile the original simple architectural conception of Radio City has had many buildings added throughout the years which do not age but add to

(*Continued on Page* 112)

Mr. Sutton is an interior designer, whose experience encompasses theatrical scenery, offices, showrooms, restaurants and night clubs, as well as product and package design. Between assignments, he relaxes by teaching the history of architecture, furnishings and costumes. He calls himself a native New Yorker, but spends much of his time traveling away from that city to consult with architects and their clients. His inclination to travel comes by experience; while he was growing up, his parents traveled so often he was educated in 38 schools.

"NO PERIOD" WOULD BE OUT OF STEP

Colin McLean, *Hospital Decorator, Chicago*

Colin McLean

I BELIEVE that a *no-period* style for our hospital interiors would put them out of step with all other public buildings.

Mr. and Mrs. America are demanding modern styling in their motor cars, their homes, their trains, and, yes, in their hospitals. Like all designs of the past, "modern," which Mr. Sutton refers to with horror, has come to us as part of our social and economic adjustments. Undoubtedly no hospital patient would want to be surrounded with gingerbread of the Victorian age, and no hospital administrator in today's labor market would want to take on the many problems involved in the maintenance of traditional furniture. Certainly no one knows what the future generation will demand stylewise 50 or 75 years from now and no one, thus far, has learned how to prevent obsolescence of design. Some of the advanced thinking for progressive medicine and patient care that will certainly be developed in the next 20 years will make it necessary to change design of existing structures.

I agree that for every new hospital completed there are 10 old institutions that look more tired and worn out than they really are, but that is the price we pay for progress, and most hospital administrators faced with problems of joining a new structure to an existing institution will develop, on paper, a program of color, furniture and physical face lifting for the old building which can be executed prior to the completion of the new structure, or over a period of years.

To borrow Mr. Sutton's opening statement, I decorate hospitals, and I would not confuse my work by attempting to decorate night clubs or restaurants. Today, hospital people wisely engage architects and decorators who specialize in institutional work and not those who attempt to be all things to all people.

Protectiveness and security (that inward assurance that things are going right) can be well expressed in modern design by a decorator who knows how to correlate warm colors, soft lights, and friendly furniture. ■

CONSIDER PATIENTS' ACHING BACKS

Joseph Blumenkranz, *Architect-Consultant, New York*

Joseph Blumenkranz

ATTRACTIVE design and patient comfort are not incompatible, as is often the case now. On the contrary, provision for the patient's welfare should be the central concern of the hospital architect, the decorator, and the furniture maker. Hospital design basically is for patients, rather than for guests of the board of trustees on opening day.

Regrettably, recent trends accentuate mere eye appeal, and this emphasis fails to take care of the patient's aching back.

The "modern" easy chair that is the vogue in our clublike hospital lounges and in our patients' rooms excels only in defying its adjective. It is seldom adjustable to the contours of the human anatomy. Moreover, its fondness for the wall behind it is so intense that the plaster literally gets carried away by it! No degree of fashionable decor can offset the offensiveness of gouged out wall finish. A "wall-saver" frame could prevent this.

There are spheres of hospital design that are not merely in the realm of decor or taste. No picture hung opposite his bed will interest a patient whose eyes smart from strain while he tries to relax with a magazine in a poorly illuminated room. If he is not depressed by the footcandle deficiency, he is writhing in the heat and glare of an incandescent bulb concentrating its hot rays on his already feverish head.

Another matter concerns daylight. Despite nightly sleeping pills, the patient awaits those intermittent daytime naps. Alas, the decorator's scheme often does not allow for shades that could darken the room for such unesthetic ends! Instead, the vogue for bamboo matchstick blinds has captured his fancy. Perish the thought of an opaque shade, even if it does accomplish its dark deed.

Frequently, a heavy drapery is hung around the window. It is so laden with dust that the slightest breeze brings on a sneezing spell along with the welcome fresh air. This feature ostensibly is a "must" to create that friendly residential feeling, as opposed to the cold clinical aspect of the patient's milieu.

Apartment dwellers undoubtedly have been startled out of slumber by a sudden blast of a neighbor's radio or television, or by a thunderous flush of water in an adjacent toilet room. But what has been done in the latest hospital plans to minimize these daily harassments? Of course, this is not merely a problem for the architect. The designers of plumbing fixtures, for example, have not advanced their product beyond the Niagara-like flushometer of 50 years ago.

When the patient is comfortable in bed, when his room is draft-free and the temperature does not defy his control, when his neighbor's radio does not jar him out of his composure, and the water-closet flush does not startle him out of his slumber, when the daylight can be shut out at will, when soothing artificial lighting makes reading a pleasure, and when other irritants and needless wear and tear are eliminated by design, the problem of the "night club" look won't much matter. ■

FUNCTION OF THE ROOM HAS CHANGED

James S. Moore, *Architect, Los Angeles*

J. S. Moore

WE DO certainly agree with Mr. Sutton's statement that a hospital should look like what it is—and that care and restraint should be exercised in today's vast program of hospital expansion.

The fact that the function of a room in a modern general hospital has changed from that of convalescent or long-term use to acute patient care should be considered in planning, in order to make nursing care easier. This does not, of course, mean a sterile, cold approach to the design of the interior, but it does weigh against unnecessary ornamentation, which sometimes is felt to be essential in making the room warm and "cozy."

Based upon research, and borne out by our own experience, we believe there are possibly three or four types of decoration and interior approach, based upon a room's function.

One type of room is the acute patient room where the patient seldom stays more than four or five days. During that time he usually is quite sick. He may have had an operation and, on the first day, he will be unconcerned with his surroundings. The second day he begins to feel better, but he still is interested in little except his own reactions. The fourth day he probably goes home. This room should be designed for efficient nursing care, since that is the most important consideration.

The second type of room is a convalescent room, where the patient may stay for two weeks or more. Obviously, there should be more space and more cheerful surroundings here, and possibly patios or terraces outside.

The third type of room is similar to the second, except that it must be more efficient because of the amount of nursing care required. This is the maternity unit, where the patient usually is very happy. There must be more area, because of the presence of another patient, the baby itself, for each patient.

Still a fourth type of room may be that used for the pediatric patient. These rooms often are multiple occupancy rooms, except for the more serious cases. They should be decorated in gay, cheerful colors that will appeal to children and divert them from fear of being ill and away from home.

Mr. Sutton is right again when he states that, more than anything else, hospital patients want a sense of protectiveness and security. Our research and experience have taught us that such assurance often comes from being able to feel close to the nurses' station and the nurse. This sometimes can be accomplished in the original plan through use of nurses' audio systems and closed-circuit television, as well as in architectural planning. ■

HOSPITAL SHOULD BE A WORK OF ART

Ann Willis, *Architect, New Jersey*

Ann Willis

MR. SUTTON is absolutely right. For a designer who is primarily concerned with the fashionable moods of the cocktail hour he has candidly expressed the heart of the entire problem. He has rediscovered the patient—the forgotten element in today's architecture—and has related his needs to hospital planning.

This is a remarkable achievement, especially so because of the unfortunate tendency of our industrial society to overlook the basic psychological needs of the individual. It is, therefore, not at all surprising to overlook the patient, to eclipse him behind glittering mechanical contrivances, or to subordinate him to the convenience of others. Mr. Sutton has placed the accent where it belongs—on the human being, the sick and lonely patient. It is for him that the hospital exists.

The "no period" style of architecture to which Mr. Sutton refers is undoubtedly the subtle combination of elements that are basic to all great architecture. Because of the very nature of its function, a hospital should be a work of art; it should supplement good medical care—by providing for the patient's well-being. A hospital should have integrity, expressing its nature in form and function. It should have simplicity and proportion and beauty for this is the trinity that makes architecture timeless and significant.

When a hospital is carefully planned, when its proportions are good and its conception is clear and simple, future expansion and changes are relatively easy. There is no awkward clash of styles; the union of the old and the new becomes almost imperceptible.

For a patient, a hospital should be sensitively conceived and free from the institutional shock of a scale beyond human conception. This, together with warm, friendly decorations and colors, is of the utmost psychological value. Since the sick are often highly sensitive, it seems reasonable to conclude that they will respond favorably to the basic elements creating a natural harmony in the hospital atmosphere.

Such are undoubtedly the things that Mr. Sutton has in mind, but he has not even indicated the enormous difficulty of the task he proposes. We are blinded by fashion and crippled by convention. Fear holds our hand and pecuniary values limit our imagination. Nevertheless, there is hope. ■

Hospitals Shouldn't Look Like Night Clubs

(*Continued From Page* 109)

each other's visual importance and prestige. It is to be hoped that new hospital buildings could follow this example.

Hospitals are houses where sickness and death are constant residents, and where emotions of the ill and their worried families warp and twist normal reactions. Probably more than anything else, the patient wants a sense of protectiveness and security—constant reassurance that everything is going to be all right. A night club is not conducive to this kind of reassurance.

It Isn't Soothing

Not everyone likes the modern treatment in interiors. I do, but a great many people (including me) fail to find it comforting and soothing when they are sick and in pain. In fact, the overdone, sleek, contemporary look in a hospital can be an insult and an affront to fear and worry and grief. To the older age group now entering hospitals in increasing numbers, it must be alien and disturbing.

By the same token the other extreme: Ersatz early American or a too homey look in patients' areas is equally unassuring. Flowered chintz and "cottage" type furnishings also hardly give a patient confidence in the fine medical and surgical care and surgery offered.

Even a picture hanging on a wall can be an irritant. A friend in the hospital recently commented on a picture hung so that he couldn't avoid looking at it. An innocuous still life done in modern style, it had a diabolical way of shifting and changing from one monstrous figure to another. To a well person it was simply a very ordinary colorful print, but to a sick patient it was a nightmare.

Somewhere in between the drabness of yesterday's alms houses and an architect's dream of tomorrow's hospital, there is a "no period" style of architecture and decorating that can be warm, comforting and designed to maintain the dignity consistent with a place of healing.

Another problem facing hospitals and their architects and designers, is renewal of obsolescence. Over the country, particularly in the larger metropolitan areas, there are aging hospital plants that will have to be remodeled and renovated if they are to give the high quality of service that the public expects.

Superimposing the new on the old can be done as a skillful blending or it can be done in such a way as to make the new look like an excrescence on the old structure. It's astonishing to see how many additions have this neoplastic appearance. Surely some governing boards have themselves gone overboard and pressured the architect into putting a modernistic wing on an old building, without recognizing that teen-age styles make even an attractive and well preserved middle aged woman look slightly ridiculous.

In expanding an old building, the handling of interiors is a problem, especially when both the new and the old units have patients' rooms. Too often, remodeling projects do not take into account, either in money or in planning, the need for redoing the old area to merge both into one harmonious whole. If that isn't done, patients of course want to be in the new quarters. They complain if they don't get there. They are unhappy with the "old" rooms. That makes doctors unhappy, too. First thing the hospital knows, the doctor is taking his patients somewhere else. Occupancy drops on the old unit, and trouble of course results.

One Can Achieve a Blend

It is neither impossible nor even especially difficult to achieve a good blend of old and new. The exterior is an architectural problem on which hospital boards would do well to listen to their architects instead of trying to direct them. Such steps as scraping off the architectural "icing" of roof lines and eaves of the old structure, and avoiding disagreeable contrasts in colors and building materials for the new, can do the job. The properly planned new unit can enhance the solid, pleasant and timeless character of the original hospital structure.

A harmonious blending of new and old in interiors can best be achieved by use of colors and by uniform floor coverings and wall treatment. This doesn't mean use of a wide range of colors, as this tends to break up and segment the hospital when just the opposite effect is desired. Rather there should be selection of two or three basic colors from which grayed and softened variations can be drawn to unify the interior. Color can thus be the principal cohesive element in masking the line of demarcation between old and new.

The modern idea of two colors on the walls of a room can be extremely disturbing to a patient unless different tones of one color are used. This decorating technic is used quite successfully in offices and homes, where one or two walls of contrasting color add depth or distance. But the hospital patient, lying in bed all day with nowhere to look but at these walls, finds that the vertical line of juncture dramatizes and points up the 90 degree angle of the corner. It closes him in like a box. However, softened versions of the same color, with a half-toned ceiling can add interest and variation without being subtly irritating to the patient.

Lower High Ceilings

High ceilings can be dropped by carrying down the ceiling color as an illusory treatment, or actually dropped to make room for ducts for air-conditioning. Tall, narrow windows can be widened by extended draperies to the side and shortened by valance boards of the wall color. These, of course, are time-honored technics that everyone knows. But they need to be done at the time the new unit is constructed and their financing should be planned right with the expansion project, to keep the original building from being typed as "old" by the public. Too often this is not done with good timing.

Fund campaigns fall short of goal or the new construction costs turn out to be greater than anticipated and the renovation of the older building is shelved for some indefinite future date. This is shortsighted and can do almost irreparable damage to the hospital's position in the community.

A hospital should look like what it is—not like a night club or a restaurant or a plush modern motel. Nor have the chilling, impersonal effect of a bus station. Its decor in patient areas should not excite or stimulate or repel. It should be attractive without being obtrusive. And because it must serve its community for many years in the future, it should seek a "no period" styling in architecture, interiors and furnishings that will still look comfortable when today's newborn return to have their own babies. ■

Robert H. Markowitz
Sheldon S. King

Mr. Markowitz (left) and Mr. King (right) discuss some problems with the referral secretary. In the file she keeps cards on which physician's name, address, specialty, hospital title, office hours, telephone number, and age are listed.

Patient Meets Doctor With Hospital's Help

This referral service builds good will by helping patients find doctors when they need them and giving young doctors a chance to build up their practices

FREQUENT changes in the community served by Mount Sinai Hospital, New York, taking the form of new housing projects and a steady influx of immigrants, have kept the population fluid. Many of the younger physicians graduating from the intern and resident programs of the hospital have become the "family doctors" for the new members of the community.

Mount Sinai Hospital originally followed the practice of referring requests from the community for physicians to an administrative secretary, who attempted to answer each inquiry. However, the number of telephone requests increased to an unanticipated level, encroaching considerably upon the already busy program of the secretary. The referral procedure became overly time consuming as the secretary attempted to select the proper medical discipline for the caller. To guard against unbalanced staff referrals and provide improved service, a systematic referral system seemed desirable.

In an effort to eliminate the unevenness and misinformation occurring, the director of the hospital recommended to the medical board that a physician referral service be established to provide the public with prompt, accurate and courteous replies to its requests for physicians. Elements of the service provide for equitable rotation of referral inquiries among the listed members of the attending staff, with accurate record keeping and follow-up procedures helping to measure and improve the service. Physicians of the hospital's attending staff who participate in the referral service have given their permission to be listed.

The referral service secretary maintains a card file for each listed attending physician, bearing the physician's name, address, specialty, hospital title, office hours, telephone number, and

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Robert H. Markowitz and Sheldon S. King, shown at left and right, respectively, in the photograph above, were both residents in hospital administration and Goldwater Fellows at Mount Sinai Hospital, New York, at the time they prepared this description of the hospital's system of referring physicians. Since that time, Mr. Markowitz, who received his master's degree in hospital administration from Columbia University this year, has been named administrative assistant at Mount Sinai Hospital, Chicago. Mr. King received his master's degree in hospital administration from Yale University and served as an administrative intern at Montefiore Hospital, New York, for three years. He is a graduate of New York University.

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age. Age is listed because experience has shown that many inquiries designate either "younger" or "older" men as part of their request. Each card contains ample space for recording the referrals, and follow-up information obtained.

As the telephone calls and letters reach the special secretary, she attempts to learn from the inquirer which clinical specialty is involved. This is done in two ways. If the prospective patient asks for the name of a physician in special practice, *e.g.* an obstetrician or a hematologist, this information is supplied. When the inquirer makes no specific reference, but merely wants the name of a "good doctor," the referral secretary offers the name(s) of a physician(s) who conducts a general practice. Experience has shown that, when a request is made for a specialist, it is usually based upon the recommendation of the caller's family physician. At no time does the secretary attempt to exercise medical judgment.

After a referral is made, the names of the prospective patient and the physician to whom he is referred are recorded in a daily log book. Later, an index card is made for each referral listed in the log book and is maintained in a permanent file.

Approximately one week after the referral, a follow-up card is mailed to the referral physician. He is asked to complete a short form indicating the disposition of the case, *e.g.* "did not call"—"made appointment"—"kept appointment." As the returns are received, the information is recorded on the individual physician referral cards and is used to accumulate utilization statistics for the referral service. Physicians' names are supplied to inquirers on a rotation basis within each specialty. A physician is credited with a referral only if the patient makes and keeps an appointment. An attempt is made to distribute all referrals equitably among the participating physicians.

Frequently a request is received for the name of a physician located in a particular geographic area. In these cases the physician's office location takes precedence over the rotation sequence in referring the caller. Other inquiries may specify the "top man" or "chief" in a particular service. When such a request has been made, the name of the chief of service is submitted to the prospective patient. Questions about staff positions and other affiliations and qualifications are answered factually.

The service was established in July 1956 and, after a slow beginning, utilization by the community increased. In the first six months of operation there was a total of 1231 inquiries and 959 referrals. Of these, 265 patients, or 28 per cent, were seen by physicians on the referral service. The average daily number of inquiries was 15 to 20.

The referral system has been functioning to the complete satisfaction of the attending staff. In the opinion of staff physicians in family practice, the referral service has been of considerable value in channeling community medical needs to them and to young physicians in general practices. It also provides them with a convenient method for referring their patients to specialists, as indicated. For the specialist groups, the service has helped in filtering out those patients whose needs can be filled best by the family physician group.

The appreciation of the community for the referral service has been expressed in thankful telephone calls and letters of commendation. As an instrument for good public relations, the physician referral service is another hospital service provided by Mount Sinai for the community, and fulfills the hospital's policy of continuing good will through effective service. ■

Surgeon's Letter Tells Patients All they Need to Know About Hospital Procedures

AUSTIN, TEX. — Patients of Dr. Joe T. Gilbert, Austin surgeon, know what to expect when they enter the hospital for an operation. To make certain all the questions patients usually ask are answered in advance, Dr. Gilbert has prepared a form letter that he gives to patients as soon as they know they are going to the hospital.

"You will be given a choice of room accommodations," the letter says. "If the room you desire is not immediately available then, you will be transferred to the type of accommodation preferred as soon as it is available."

The letter explains that Austin hospitals are nonprofit, community enterprises. "They are extremely expensive to operate," it adds. "You will be asked for a deposit on your bill at the time of admission. The amount of the deposit required will be determined by the type of care anticipated. The possession of most types of hospital insurance will exempt you from this deposit."

Hospital regulations governing check-out time are then explained, and the letter goes on to provide special information for patients admitted to the hospital for surgery.

This part of the letter states that the operation has been scheduled at the indicated hospital, which is named in the letter. The patient is then instructed as to the time of admission and the recommended diet for the previous day.

Other details in the Gilbert form letter include:

1. *Special nurses*: "If I feel that they are indicated, I shall so inform you. If you desire special duty nurses, please notify me, the superintendent of nurses, or the admitting office. The fee for special duty nurses is $12 for each eight-hour shift."

2. *Hospital and surgical insurance*: "If you have hospital or surgical insurance, bring the policy to the hospital admitting desk with you. Persons familiar with the various types of insurance are assigned to the admitting office. They will advise you regarding the completion and signing of your portion of the insurance blanks and see to the proper completion and signing by your physician."

3. *Costs*: "Daily room rates are from to (approximately). More expensive, connecting-bedroom suites are available on request. . . . A charge is made for use of the operating room. This is determined by the type of surgery and length of time it requires. An approximate figure for your type of operation will be obtained for you if you ask. Charges are routinely made for the necessary laboratory work and medicine that you will require. Additional charges for x-rays, dressings, additional laboratory work, and so on may be required during your hospitalization."

4. *Recovery room*: "There is a recovery room to which all patients who have had general anesthesia are transferred after surgery."

In addition, the letter discusses the surgeon's fee, the surgical assistant and his fee, and the anesthetist and his fee.

PROTOTYPE STUDY:

150 BED PROPRIETARY HOSPITAL

Continuing a new series of prototype studies of proprietary short-term general hospitals with up-to-date information on principal departments

LOUIS BLOCK, Dr. P.H.

Chief, Research Grants Branch
Division of Hospital and Medical Facilities
Public Health Service, Washington, D.C.

THIS is the sixth of a series of prototype studies on the proprietary short-term general hospital in the United States. Such hospitals, while they represent only 2.3 per cent of all hospital beds and 6.5 per cent of all beds in general short-term hospitals, do represent 15 per cent of all hospitals in the United States and 20 per cent of all general short-term hospitals. Previous articles have considered the 25, 50, 75, 100 and 125 bed hospitals. A future article will describe the 15 bed proprietary hospital. Comparisons between the proprietary and nonprofit hospital accompany each article except for the 15 bed hospital, where no comparable figures are available.

LABORATORY

Frequency of Hospitals Having:	Per Cent of Hospitals
Physician staff member specializing in pathology	93
a. Full-time	45
b. Part-time	48
All tissue removed at surgery routinely examined by a pathologist	93
Urinalysis on all admissions	87
Blood count on all admissions	76
Serological examination for syphilis on all adult admissions	47
Electrocardiograph on all admissions over 45 years of age	0-1
Rh grouping on all pregnancy cases	64
Preoperative blood grouping on all surgical cases	41
Preoperative coagulation on all tonsillectomies	78
Postoperative urinalysis on all surgical cases	32
No tests without doctor's orders	13-14
Laboratory facilities available to private ambulatory patients of physicians	80

PURCHASING

A central purchasing department is to be found in 87 per cent of the 150 bed hospitals. A full-time purchasing agent is employed by 33 per cent of the hospitals which have central purchasing.

BED DISTRIBUTION

In most 150 bed hospitals there is a specific bed assignment for special patient groups. Where more than 50 per cent of such hospitals within this size group make such an assignment they are usually considered as having specific bed assignments for purposes of this study. Where bed assignments occur in less than half of these hospitals they are considered as unassigned. The following tabulation shows the specific or unassigned service groupings, the frequency with which they occur, and the average number of beds that are assigned to them:

Medical-surgical patient beds	
a. Frequency of occurrence	4 in 5 hospitals
b. Average number of beds assigned	109
Obstetrical patient beds	
a. Frequency of occurrence	4 in 5 hospitals
b. Average number of beds assigned	28
Pediatric patient beds	
a. Frequency of occurrence	7 in 10 hospitals
b. Average number of beds assigned	13
Isolation or contagious patient beds	
a. Frequency of occurrence	1 in 11 hospitals
b. Average number of beds assigned	4
Psychiatric patient beds	
a. Frequency of occurrence	1 in 11 hospitals
Tuberculosis patient beds	
a. Frequency of occurrence	1 in 25 hospitals

SAFETY

An organized safety committee is to be found in 52 per cent of the hospitals, written fire emergency and evacuation plans are found in 66 per cent, while regularly scheduled fire drills are held in 38 per cent. A written plan for mobilization of employes and medical staff is available in 43 per cent of the hospitals studied, 41 per cent have integrated this plan into the master community plan, and a hospital representative sits on the community disaster planning committee in 70 per cent.

RELIGIOUS

Frequency of Hospitals With:	Per Cent of Hospitals
A chapel	0
A meditation or prayer room	2
An organized visiting clergy staff	33
A chaplain available	62
A full-time chaplain	2
A part-time chaplain	4
A chaplain on call only	58

LAUNDRY

One in three of the hospitals studied operates its own laundry and processes all soiled linens. In those hospitals 6150 pounds of laundry are processed per week and 320,000 pounds per year, averaging eight pounds per patient per day. For those hospitals which do not operate their own laundry, two in three, 7700 are processed per week, or a total of 400,000 pounds in a year, for an average of 10 pounds per patient day.

UTILIZATION

An analysis of the kind, type and number of patients admitted to and using the 150 bed proprietary hospital annually shows 6000 admissions; 40 admissions per bed; 1090 live births; 40,000 patient days of care, and 5100 newborn infant days of care.

The daily adult census in the hospital is 110. The daily newborn census is 14.

The percentage of adult occupancy, then, is 73 and the average length of patient stay, 6.7 days.

AMBULANCE

Frequency of Hospitals Which:	Per Cent of Hospitals
Provide ambulance service	98
Operate own ambulance	0
Use city or publicly owned ambulances	0
Use private nonhospital ambulances	98

COMPARISON OF 150 BED PROPRIETARY GENERAL HOSPITAL

The following indicates certain areas of similarity and difference between the 150 bed nonprofit general hospital and the 150 bed proprietary general hospital:

BED DISTRIBUTION

1. At least half of these hospitals in each control group make specific bed assignments for medical-surgical, obstetrical and pediatric patients. The proprietary hospital assigns a greater number of medical-surgical beds, an equal number of obstetrical beds, and a lesser number of pediatric patient beds.

UTILIZATION

1. The proprietary hospital shows fewer admissions, census, births, newborn days of care, occupancy and average length of patient stay.
2. In other areas, such as adult days of care and newborn census, both groups are similar.

SERVICES

1. This size hospital in both control groups usually provides a blood bank, central supply room, clinical laboratory, electrocardiograph, basal metabolism apparatus, medical library, medical record department, outpatient department, pharmacy, premature nursery, x-ray diagnosis and x-ray therapy.
2. The nonprofit hospital will, in addition, have a hospital auxiliary, physical therapy department, and patient library.

FINANCIAL

1. Both total assets and plant assets are less in the proprietary hospital.
2. Both total and patient income are greater in the proprietary hospital.
3. Per cent patient income of total income is greater in the proprietary hospital.
4. Both total expense and payroll expense is greater in the nonprofit hospital. The proportion payroll of total expense is also greater in the nonprofit hospital.

PERSONNEL

1. The proprietary hospital has fewer total full-time employes than the nonprofit hospital does. This is also true on a per patient and an occupied bed basis.
2. The proprietary hospital is less likely to have an organized auxiliary.
3. The average number of volunteers contributing service is less in the proprietary hospital.
4. Total graduate nursing personnel is less in the proprietary hospital. This is reflected in a lesser number of graduate general duty nurses, both full-time and part-time.
5. When such personnel is employed, the proprietary hospital shows a greater number of private duty nurses, practical nurses, ward maids and medical technologists; a lesser number of attendants and orderlies; and an equal number of nurse's aides, x-ray technicians, medical record librarians, pharmacists, other medical record personnel, dietitians, and medical social workers.
6. When such service is provided, the nonprofit hospital is more likely to have a registered, full-time occupational therapist and a registered full-time physical therapist; whereas, the proprietary hospital is more likely to have such full-time personnel other than registered.

MEDICAL STAFF

1. There is general similarity in organization of the medical staff in both control groups as evidenced in committees established.
2. The frequency with which both groups have surgical restrictions on the medical staff is about the same.
3. The nonprofit hospital is more likely to be accredited by the Joint Commission.
4. The proprietary hospital has more staff appointments.

NURSERY

1. The proprietary hospital has fewer bassinets.
2. The nonprofit hospital is more likely to have special nurseries for premature infants and infant incubators.
3. There is a similarity in the number of incubators provided in both groups, when provided.

ADMINISTRATOR

1. Although in both hospital groups the administrator is more likely to be a person who is other than a physician or a nurse, the proprietary hospital is more likely to have a physician as administrator than is the nonprofit hospital.
2. In the nonprofit hospital the administrator is more likely to be a graduate of a college course in hospital administration.
3. In the proprietary hospital the administrator is more likely to be a male, while in the nonprofit hospital the administrator is equally as likely to be a female as a male.
4. Administrative responsibility is delegated to the night nursing supervisor about equally in both groups.

RADIOLOGY

Frequency of Hospitals Having:	Per Cent of Hospitals
Physician staff members specializing in radiology	90
a. Full-time	54
b. Part-time	36
X-ray facilities available to private ambulatory patients of physicians	83
Chest x-ray on admission	12

PHARMACY

Almost three in five of the 150 bed hospitals operate a pharmacy. Of these, almost one in two have a full-time licensed pharmacist. Three in five of these hospitals have a drug formulary. In those hospitals having a full-time pharmacist, two are employed.

OUTPATIENT DEPARTMENT

Annual number of outpatient visits	11,500
Annual number of emergency visits	2,850

ACCOUNTING

Depreciation is calculated in 97 per cent of the hospitals, the depreciation being funded in 14 per cent. Twenty per cent of the hospitals operate under formal budgets, and 65 per cent use the American Hospital Association Chart of Accounts. (*Cont. on Page* 118)

WITH THE 150 BED NONPROFIT GENERAL HOSPITAL

OPERATING ROOMS

1. It is more likely that the nonprofit hospital will have one more operating room than the proprietary hospital.

LABORATORY

1. The proprietary hospital is more likely to have a physician staff member specializing in pathology. He is also more likely to be on a full-time basis in the proprietary hospital.

2. There is similarity in both groups in the frequency of those hospitals requiring postoperative urinalysis on all surgical cases.

3. The nonprofit hospital shows a greater frequency in requiring that all tissue removed at surgery be routinely examined by a pathologist; urinalysis on all admissions; blood count on all admissions; serological examination for syphilis on all adult admissions, electrocardiogram on all admissions over 45 years of age, and preoperative blood grouping on all surgical cases.

4. The proprietary hospital shows a greater frequency in requiring Rh grouping on all pregnancy cases.

RADIOLOGY

1. Although the nonprofit hospital of this size shows a greater frequency of physician staff members specializing in radiology, they are likely to have a greater proportion of them on a part-time basis than is the proprietary hospital.

PHARMACY

1. The proprietary hospital shows a lesser proportion operating pharmacies. In those that do, they also show a lesser proportion employing full-time pharmacists.

2. Both groups have a formulary with the same frequency.

OUTPATIENT DEPARTMENT

1. The nonprofit hospital shows a greater number of both outpatient visits and emergency visits.

MEDICAL RECORDS

1. The proprietary hospital of this size is less likely to microfilm medical records.

DEATHS AND AUTOPSIES

1. Although per cent autopsies of deaths is the same in both groups, the proprietary hospital shows fewer deaths and autopsies.

2. The nonprofit hospital is more likely to use the Standard Nomenclature of Diseases and Operations.

ADMITTING

1. The proprietary hospital is less likely to routinely admit patients with special diagnoses.

ACCOUNTING

1. The proprietary hospital more frequently calculates depreciation, but funds it less frequently than does the nonprofit hospital.

2. The proprietary hospital less frequently operates under a formal budget and less frequently uses the American Hospital Association Chart of Accounts.

PURCHASING

1. Although the frequency with which the proprietary hospital has a central purchasing department is greater, the nonprofit hospital is more likely to have a full-time purchasing agent.

PUBLIC RELATIONS

1. The proprietary hospital is less likely to employ methods of obtaining opinions concerning the hospital than is the nonprofit hospital.

DIETARY

1. The proprietary hospital is more likely to provide a selective menu for all patients.

LAUNDRY

1. The proprietary hospital is less likely to operate its own laundry. When it does, the volume of work performed is less in the proprietary hospital than it is in the nonprofit hospital.

2. When laundry is done on the outside, the proprietary hospital shows a greater amount than when it operates its own laundry.

SAFETY

1. There is similarity in both groups in the frequency with which they have a written plan and hold regularly scheduled fire drills.

RELIGIOUS

1. The proprietary hospital is less likely to provide religious facilities such as a chapel or meditation room than is the nonprofit hospital.

2. The same is true with regard to chaplain or visiting clergy services.

AMBULANCE

1. The proprietary hospital more frequently provides ambulance service. This is true in its use of private nonhospital ambulances. It is less likely to operate its own ambulance.

SERVICES

Where services are provided in more than half of these hospitals they are considered as being available in terms of this study. Services that might be provided but are found to occur in less than 50 per cent of these facilities are considered as unavailable. Certain of these services might be provided through arrangements with other hospitals and sources. Such arrangements are not reflected in the frequencies shown.

Frequencies of Hospitals Offering:	Per Cent of Hospitals
Clinical laboratory	98
Basal metabolism apparatus	98
Electrocardiograph	98
Central sterile supply room	73
Blood bank	71
Electroencephalograph	20
Dental department	16
Hospital auxiliary	6
Medical record department	100
Operating rooms	96
Obstetrical delivery rooms	90
Medical staff library	67
Pharmacy	55
Physical therapy department	39
Postoperative recovery room	29
Occupational therapy department	8
X-ray diagnosis	98
X-ray therapy	61
Premature nursery	51
Radioactive isotope therapy department	18
Routine chest x-ray on admission	12
Social service department	4
Outpatient department	55
Patients' library	21
Cancer clinic	17
Rehabilitation department	2
Children's educational program	0
Mental hygiene clinic	0

PERSONNEL

The number of full-time personnel employed by the prototype hospital is 203. The number of full-time personnel per 100 patients is 185, with the number of full-time employes per patient bed, 1.35, and the number of full-time employes per occupied bed, 1.8.

Only one in 50 of the 150 bed hospitals has an organized auxiliary. For those hospitals having an organized auxiliary, the average membership is two, with the average number of auxiliary members working in the hospital numbering zero. The number of persons other than hospital auxiliary contributing volunteer service is 15.

A graduate nursing staff numbering 46-47 is employed as follows: 2, or 5 per cent, in an administrative capacity; 4, or 9 per cent, as supervisors and assistants; 11, or 24 per cent, as head nurses and assistants; 22-23, or 48 per cent, as full-time general duty nurses; 7, or 15 per cent, as part-time general duty nurses. Thirteen nurses would be available for private duty.

The average number of other nursing personnel at the hospital is: practical nurses, 26-27; attendants, 6; nurse's aides, 32; ward maids, 10, and orderlies, 8.

Where they are employed at all (see chart on this page), the hospital has the following full-time personnel: pharmacists, 2; other medical record personnel, 3; dietitians, 2; medical social workers, 1.

Also, the hospital will appoint full-time help in the following categories: medical technologists (two registered, three-four unregistered); x-ray technicians (one registered, two unregistered); medical record librarians (zero-one registered, one unregistered); occupational therapists (one unregistered); physical therapists (zero-one registered, one unregistered). One unregistered part-time medical technologist might also be employed.

MEDICAL STAFF

The frequency of hospitals having certain services and organizational relationships is as follows:

	Per Cent of Hospitals
Chief of staff	95
Chiefs of services	89
Written staff regulations	89
Regular staff meetings	97
Standing staff committees	89
Executive staff committee	81
Medical record committee	81
Credentials committee of staff	76
Tissue committee of staff	57
Education committee of staff	21
Pharmacy committee of staff	22
Dietary committee of staff	28
Nursing committee of staff	51
Psychiatrist on staff	66

Surgical restrictions are placed on the staff by 89 per cent of the hospitals. Nonstaff members are permitted to practice in 22 per cent of the hospitals.

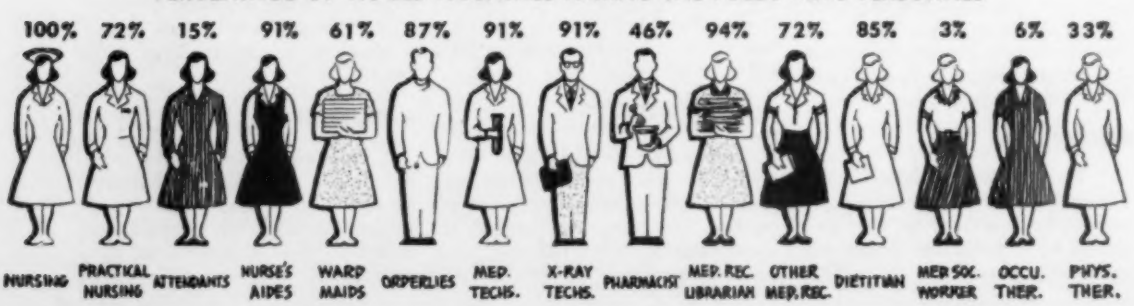
Examining rooms for patients of the medical staff are provided in 59 per cent of the hospitals; private physicians' offices in or on the hospital grounds are provided in 51 per cent; x-ray facilities are available to private ambulatory patients of the staff in 85 per cent, and laboratory services to such patients in 80 per cent.

Sixty-three per cent of the hospitals have received accreditation by the Joint Commission on Accreditation of Hospitals.

The number of staff physician appointments averaged 162, including: active staff, 39; associate staff, 9; cour-

(*Continued on Page* 121)

PERCENTAGE OF 150 BED HOSPITALS HAVING THE FOLLOWING PERSONNEL



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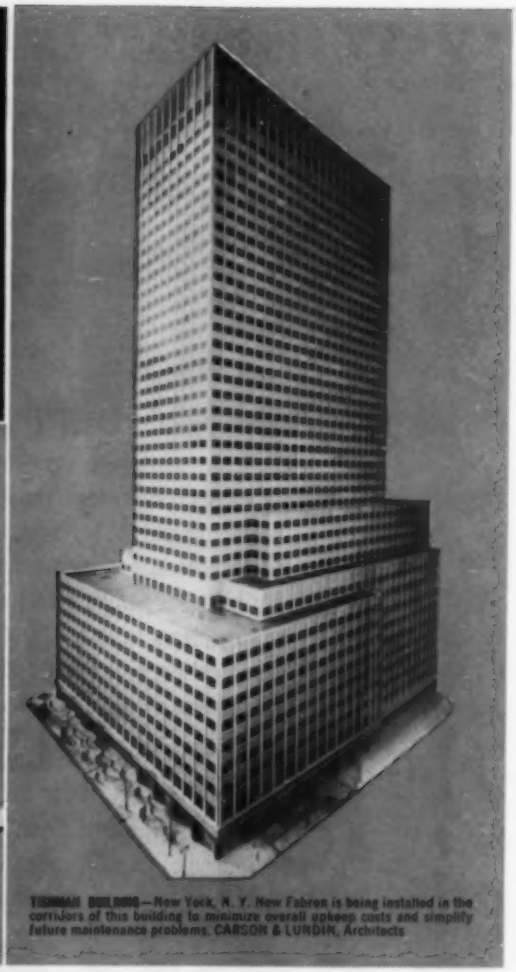

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(*Continued From Page* 118)

tesy staff, 102; consultant staff, 10-11; honorary staff, 1-2.

The number of staff physician appointments per 100 beds averaged 108, divided as follows: active, 26; associate staff, 6; courtesy staff, 68; consultant staff, 7; honorary staff, 1.

Where 50 per cent or more of these hospitals had particular staff relationships or services it was considered as being the normal practice in this study. Where less than 50 per cent had them, they are considered as not being normally available.

ADMINISTRATOR

Frequency of Hospitals Where Chief Administrative Officer:	Per Cent of Hospitals
Is a physician	22
Is a nurse	14
Is other than a physician or nurse	64
Is a graduate of a college course in hospital administration	15
Is a male	82
Is a female	18

There is a full-time assistant administrator in 49 per cent of the hospitals. Administrative responsibility is delegated to the night nursing supervisor in 76 per cent, while an administrative staff member is on duty at night in 19 per cent.

OPERATING ROOMS

Number of operating rooms	4-5
a. Major operating rooms	2-3
b. Minor operating rooms	2

DIETARY

Frequency of Hospitals With:	Per Cent of Hospitals
Dietitians (full-time or part-time)	85
Central food service layout	87
Decentralized food service layout	13
Selective menus for all patients	39
Selective menus for private patients only	28
No selective menus	33
Manual and centralized dishwashing	7
Manual and decentralized dishwashing	7
Mechanical and centralized dishwashing	79
Mechanical and decentralized dishwashing	7

PUBLIC RELATIONS

Frequency of Hospitals Using:	Per Cent of Hospitals
Booklet for patients	27
Booklet for employes	14
Regularly published house organs	6
Printed annual report	14
Patient opinion poll	34
Personnel opinion poll	8
Medical staff opinion poll	14
Community opinion poll	0
No polls	60

NURSERY

The 130 bed hospital has 24 bassinets. Thirty-seven per cent of these hospitals have special nurseries for premature infants. In those hospitals having them, there are 4 infant incubators. Bead bracelets are used for identification in 88 per cent of the hospitals; tape bracelets are used in 12 per cent.

FINANCIAL

Total assets	$375,000
Total assets per bed	$ 3,800
Plant assets	$405,000
Plant assets per bed	$ 2,700
Per cent plant assets of total assets	71.1%
Total annual income	$920,000
Total income per patient day	$ 23
Annual patient income	$870,000
Patient income per patient day	$ 21.75
Per cent patient income of total income	95%
Total annual expenses	$865,000
Total expenses per patient day	$ 21.60
Annual payroll expenses	$460,000
Payroll expense per patient day	$ 11.50
Per cent payroll of total expenses	53%

MEDICAL RECORDS

Only one in five of the hospitals microfilms medical records. Four in five of the hospitals use the Standard Nomenclature of Diseases and Operations.

DEATHS AND AUTOPSIES

There are 121 deaths annually in the prototype hospital. These deaths make up 2 per cent of admissions. The number of annual autopsies performed is 31, being 26 per cent of the total number of deaths. Seven of the annual deaths are released to legal authorities, or 0.1 per cent of admissions.

ADMITTING

Admitting records are duplicated by a typewriter in 65 per cent of the hospitals studied and by hand in 26 per cent. None of the hospitals use mimeograph, liquid and gelatin or plate imprint duplicating methods.

The following percentage of hospitals routinely treat patients with the indicated diagnosis:

	Per Cent of Hospitals
Alcoholics	18
Cancer	88
Cardiac	100
Dermatologic	79
Drug addiction	7
Epileptic	22
Gynecologic	92
Isolation (contagion)	11
Medical	98
Mentally deficient	2
Neurologic	57
Obstetric	89
Ophthalmic	86
Orthopedic	100
Otorhinolaryngologic	86
Poliomyelitis	11
Psychiatric	9
Surgical	100
Tuberculosis	11
Urologic	97
Venereal disease	16
Acutely ill	100
Chronically ill	55
Convalescent and rest	4
Geriatric	39
Industrial	82
Pediatric	91

Pharmacy Students Learn About Hospitals

Not all of the pharmacy interns who take the training described here will wind up as hospital pharmacists, but those who do will have a much better understanding of hospital problems and their future hospital employers will benefit, too

ONE of the things Athens General Hospital, Athens, Ga., lacked in 1955 was a registered pharmacist. To render the best patient care in the most efficient and economical manner, the newly appointed administrator, William H. Thrasher, felt that a registered pharmacist was needed to serve as part of the health team at the hospital, as well as to meet the requirements of the law.

The authors are William H. Thrasher, administrator, Athens General Hospital, Athens, Ga.; Lollie D. Smith, chief pharmacist, Athens General Hospital; Dr. Kenneth L. Waters, dean, school of pharmacy, University of Georgia, and Dr. Charles W. Hartman, associate professor of the school of pharmacy, University of Georgia. Since this article was prepared, Mr. Thrasher has been appointed administrator of a new hospital in DeKalb County, Georgia.

Working with Dean Kenneth L. Waters of the University of Georgia School of Pharmacy in Athens, Mr. Thrasher employed Lollie D. Smith, an alumna of the school who had extensive experience in the hospital field.

Mr. Thrasher and Associate Professor Charles W. Hartman felt that if the hospital and pharmacy school could cooperate on an educational training program, both would benefit. Toward the end of the summer the hospital pharmacist was placed on the faculty of the University of Georgia. A plan was devised whereby all students of the school of pharmacy would spend a certain amount of time at the hospital working under the supervision of the pharmacist as part of their senior curriculum.

This program was met with such enthusiasm by the students that a third unanticipated value has been realized. Besides the pharmaceutical training they receive, and the value the hospital receives from their work, the students gain an insight into the fundamentals of hospital operation.

These potential pharmacists, when they move into professional life, will have a better understanding and appreciation of the needs of a hospital. Though they may never be directly connected with a hospital, having had this opportunity to familiarize themselves with a hospital pharmacy's prac-

Senior pharmacy students Dorman L. Harper (center) and Marion R. Jenkins (right) learn something about administrative problems from William H. Thrasher, administrator.

Lollie D. Smith (right), chief pharmacist of Athens General Hospital, supervises the practical pharmacy experience given to senior pharmacy students during their training.

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tices and problems, they will be better equipped to cooperate with their local hospital toward the common goal of better patient care.

The work at the hospital is part of the laboratory of the senior dispensing course. The seniors spend 15 hours per quarter for two quarters at the hospital. The grades they receive for this laboratory course are based on their knowledge, the professional manner in which they conduct themselves, their interest in learning and in their work, and personal appearance. During their course of study, they are taken on a tour of the hospital to show them something about the functions and purposes of the various departments. The administrator talks to them about general hospital operation.

The educational value to the student of such a program is immeasureable. This practical experience gives the potential pharmacist an opportunity to see his years of learning and training assimilated and applied. It helps him gain self-confidence, giving anyone who is not sure of himself the chance to practice the art of filling prescriptions with care.

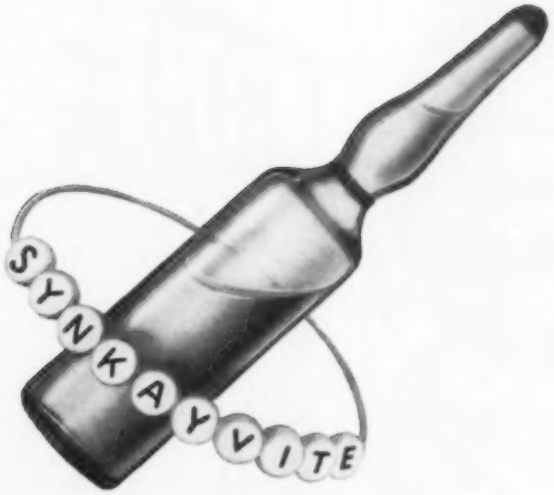
The potential pharmacist benefits by his professional contact with doctors, nurses and other medical personnel. He is exposed to medical terminology and treatment associated with acute illnesses, and he sees how doses of drugs that far exceed average doses are used in the treatment of these acute illnesses. New drugs and trade names are presented for his study.

The student is shown that a pharmacist can render a broader service than merely dispensing drugs. He is shown how, working closely with the administrator and the medical and nursing staff, a more significant pharmacy service program can be introduced and supervised. This service that a pharmacist can render reaches every department of the hospital, and the innumerable services of this department can be of value to every other department in the hospital. The relationship between the nursing unit and the pharmacy is the core of pharmaceutical service for the hospital. The student is shown how vital the correct interpretation of orders is in dispensing drugs. His responsibility in making sure that the correct and easiest dosage form is dispensed is reemphasized. He is shown that what he does or may fail to do many times means the difference between life and death.

Besides the dispensing duties that the pharmacist must perform, the alert pharmacist will offer many other services to other departments in the hospital. For other members of the medical profession, a current products file is maintained. The students are responsible for helping keep this up to date. For the emergency room, a comprehensive file on poisons and antidotes is made, and a necessary supply of antidotes is kept in stock; formulas are obtained and made for the dietary department, and this department is supplied with various dietary charts which the pharmacy obtains. For the laundry, a list of stain removers and necessary chemicals is kept; this service also is performed for the housekeeping department. For the x-ray department and the laboratory, weighing of chemicals and preparation of solutions can be done.

The pros and cons of a formulary are discussed. Working under a formulary principle gives students the experience of associating trade names with generic names. The purpose of the automatic stop order on dangerous drugs is discussed.

The value of control in purchasing is



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Recent clinical reports (J.A.M.A. *164*:1331, July 20, 1957) have stressed the adequacy of low doses of water-soluble vitamin K analogs for infants and especially the undesirability of excess dosage in prematures. So you will be glad to know of these two new dosage forms of Synkayvite:

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explained, and the value of economical and quality buying is covered. The practical application of record keeping is demonstrated, and the value of budgeting to the department and to administration is presented. Methods of determining and maintaining adequate mark-up are discussed.

A more intensive study of general hospital operation is presented in another course, called "Hospital Pharmacy," and students in this class are allowed more time at the hospital.

This program has benefited the hospital pharmacy in that, while these students are learning, they have been of assistance to the pharmacist by performing the time consuming details of setting up stock bottles for the floors, checking in orders, helping take inventory, and helping maintain a literature file.

Each product in stock in the pharmacy is listed on an index card, and the location of this product on the shelves, which are numerically arranged, is noted on the card. This file is for relief pharmacists and students to use in locating products. The students are responsible for helping set up these cards and for putting new drugs into stock. This has given them the opportunity to become familiar with hundreds of trade preparations and the dosage forms, and saved hours and hours of the pharmacist's time.

The students have assisted in preparing bulk solutions, compounding ointments, and making capsules and other special preparations, thereby saving the hospital a considerable amount of money. It should be pointed out here that a program of this type should not be undertaken with the idea of obtaining cheap labor, but with the objective of mutual benefit to the students, the pharmacy school, and the hospital where the students train.

From the results of the experience gained from the intern training program at Athens General Hospital the following conclusions can be drawn:

Pharmacy students gain confidence, increase their professional ability, become better integrated into the health team, become familiar with the problems of hospital administration, and in general acquire a broader knowledge and a greater appreciation of not only their own profession but also the professions of other members of the health team. An intern program such as this can be worked out satisfactorily by other schools of pharmacy and hospitals with benefit to both. ■

Good Design Steps Up Laboratory Production

This discussion of the elements that must be considered in the design of a new laboratory, or remodeling of an old one, also brings out the effects of proper equipment and design on technicians' ability to get work done

Seward E. Owen, E. P. Finch, and W. H. Byers

THERE are many elements to consider in modernizing and adapting available laboratory space, as well as in planning new construction. Among them are space, location, efficiency, traffic flow, power utilities and lighting, temperature and ventilation, safety and sanitation, equipment and related items.

The space allotted for laboratories can be based on bed capacity, average expected daily patient load, and types of service to be provided. The future growth of the laboratory facilities also must be planned. This may be done by new construction or by making the facilities adjacent to the laboratory of such a nature that they can be used later for laboratory purposes.

In a general medical and surgical hospital, the laboratory test load will be approximately 1.27 per average patient day. For a hospital serving patients with chronic illnesses, the average test per patient day approximates 0.60. Well trained laboratory technologists can accomplish an average of from 800 to 1000 tests per month.

Each technologist requires an average of 25 square feet of clear bench top space. The depth of the bench top is usually 30 inches. Thus, 10 linear feet of bench are required. It is good practice to have at least 5 feet in front of the bench as clear floor space. The basic bench and floor area per worker is 75 square feet, but this does not include space for incubators, refrigerators, centrifuges, ovens, heating equipment, sink areas, or traffic lanes. Space for these, plus the bench and clear area noted, requires 150 square feet of floor space per worker.

Dr. Owen is chief of the laboratory section in the clinical laboratory service at Veterans Administration Hospital, Hines, Ill.; Mr. Finch is supervisor of Unit I laboratory there, and Mr. Byers is a biochemist in the laboratories.

The article is published with the approval of the chief medical director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

Include Associate Activities

In over-all planning there are many associated activities to be considered, including offices, blood donor rooms, secretarial work area, storage and locker rooms, lavatories, animal quarters, morgues, classrooms, conference or training rooms, gastric test room, basal metabolism room, and possibly electrocardiography rooms, as well as others. Many of these may be planned separately, but if they are included in the over-all space to be allotted the laboratory they will double the space required for medium size and large laboratories. The total floor space per worker thus becomes 300 square feet for all activities. This figure includes traffic lanes within the laboratory but not the hallways outside. If facilities for x-ray are included, extra space must be provided.

Despite these factors, many planners are inclined to recommend a specific number of square feet of laboratory space per each hospital bed serviced.

Location of the clinical laboratories should be central. The ambulatory house patient as well as the outpatient must have easy access to the laboratory. Highly desirable also is nearness to the reception service, operating suites, wards and the necropsy rooms. At least two entrances to the laboratory should be provided, in addition to the connecting office doors and adjacent rooms. If the laboratory is sectionalized into rooms, doors to all sections should be at least 42 inches wide to permit wheel-chair and litter entrance.

Basement locations for laboratories should, in general, be avoided because of possible dampness and lack of daylight and good ventilation. Such specialties as histopathology are preferably located in separate rooms because of odor and other circumstances. Animal quarters and morgues are perhaps better provided for in buildings separate from the hospital proper.

Efficiency factors are affected by many things. The nature of specimens, equipment and apparatus usually indicates that such activities as chemistry and urinalyses are best done at benches 36 inches high. Each of these activities needs one or more adjacent sinks. The sinks should be at least 8 inches deep and no smaller than 14 by 20 inches. Center trough sinks have not proved satisfactory for use on double width benches. All sinks should have a gooseneck mixing type of faucet with the outlet approximately 6 inches above the sink top. Base cabinets should have many drawers. Wall cabinets may be mounted above the workbench if the latter is against a wall. Wall cabinets 10 inches deep and 36 inches high, installed 15 to 18 inches above the bench top, serve well. Sliding glazed doors are suggested for these cabinets. Special-

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ties such as hematology, serology, bacteriology and parasitology are conveniently done at benches 30 inches high. Knee spaces in these should be not less than 24 inches wide. Chairs having adjustable seats and back rests, and with casters on the legs, are recommended. Matching stools without back rests are preferred by some workers.

Related specialties which may be grouped are: bacteriology-parasitology-serology; hematology-transfusions; chemistry-urine analyses. Such groupings favor streamlined work flow patterns and integrate well with the usual traffic patterns.

Must Control Traffic

Traffic flow patterns exist in all hospitals and, as on highways, the traffic may be congested or freely flowing depending upon the foresight of the planners. In the average hospital the laboratory service is large enough so that its traffic plan should be integrated into the over-all hospital arrangement. Interservices traffic problems are of less direct importance than intralaboratory traffic, since the latter directly affects laboratory efficiency. Within the laboratories, adjacent or near-by storage for reserve supplies, and unit or sectional storage for supplies in everyday use will reduce unnecessary traffic.

Central free floor space is needed in most laboratory sections and, as noted previously, space between benches should not be less than 60 inches for the 36 inch high benches and not less than 80 inches where stools or chairs are used, as between the 30 inch high benches. In larger laboratories each department or section should have its own equipment such as centrifuges, refrigerators, incubators and water baths to reduce worker and specimen travel.

An adequate waiting area for patients should be provided. Preferably this should be outside the laboratory work area. Four easy chairs and space for two wheel chairs and one wheeled litter are suggested for each 100 active beds in the hospital. A good arrangement permits patients to be brought into the laboratories one at a time for specimen collection. A near-by patient lavatory should not be forgotten. Floor space near the bench areas should be adequate to permit this individual service. Blood specimens should not be drawn where waiting patients can observe this activity. Many laboratories find a separate specimen collection room a solution.

The usual service lines for gas, electricity, water, vacuum and pressure should permit some freedom in workbench arrangement. Horizontal supply lines behind benches at walls, with appropriate risers and outlets, appear best. These outlets should not pierce the bench top but rather should be along the wall behind benches or in a boxed-in step shelf at the rear of the bench. Electrical amperage needed should be calculated at least 100 per cent above existing requirements to provide for future equipment. Multiple circuits, all grounded at the equipment receptacles, are suggested. Special circuits at 220 volts and 6 volts, if included, must be labeled, and these should have characteristic receptacles to prevent error in use. The fuse box for 12 to 16 circuits should be in or near the laboratory proper, and all circuits must be labeled in the box. Gas, air, water and vacuum lines for the benches and hoods should have easily accessible, separate line shut-off valves, in addition to stopcock at the benches.

General Cleaning Area

Although individual sinks should be provided in each activity center, there should be a general washing and cleaning area. This section should have deep stainless steel sinks with splash rims and back apron. The drainboard area should be planned to accommodate automatic washers and automatic pipette flushing apparatus. Storage in this area should be planned for the usual cleaning agents and for clean and soiled glassware. Lighting should give adequate, shadow-free illumination of about 25 to 35 footcandles at the benches. It is best to have two smaller hoods so that one may be used safely for evaporation of organic solvents. The hoods are preferably located in the chemistry section.

Air conditioning or air cooling is highly desirable, since either reduces dust and tends to maintain even room temperature during hot weather. Thermostatically controlled heating is recommended for the colder months. Equipment such as autoclaves, ovens and incubators must have adequate ventilation or exhaust systems, and the heating system must be planned to give the required air exchanges. In laboratories not air cooled or air conditioned we have found that reversible exhaust fans in window transoms and wall mounted fans aid in ventilation. Heating radiators below windows are preferred, but they do use up bench top space in some cases.

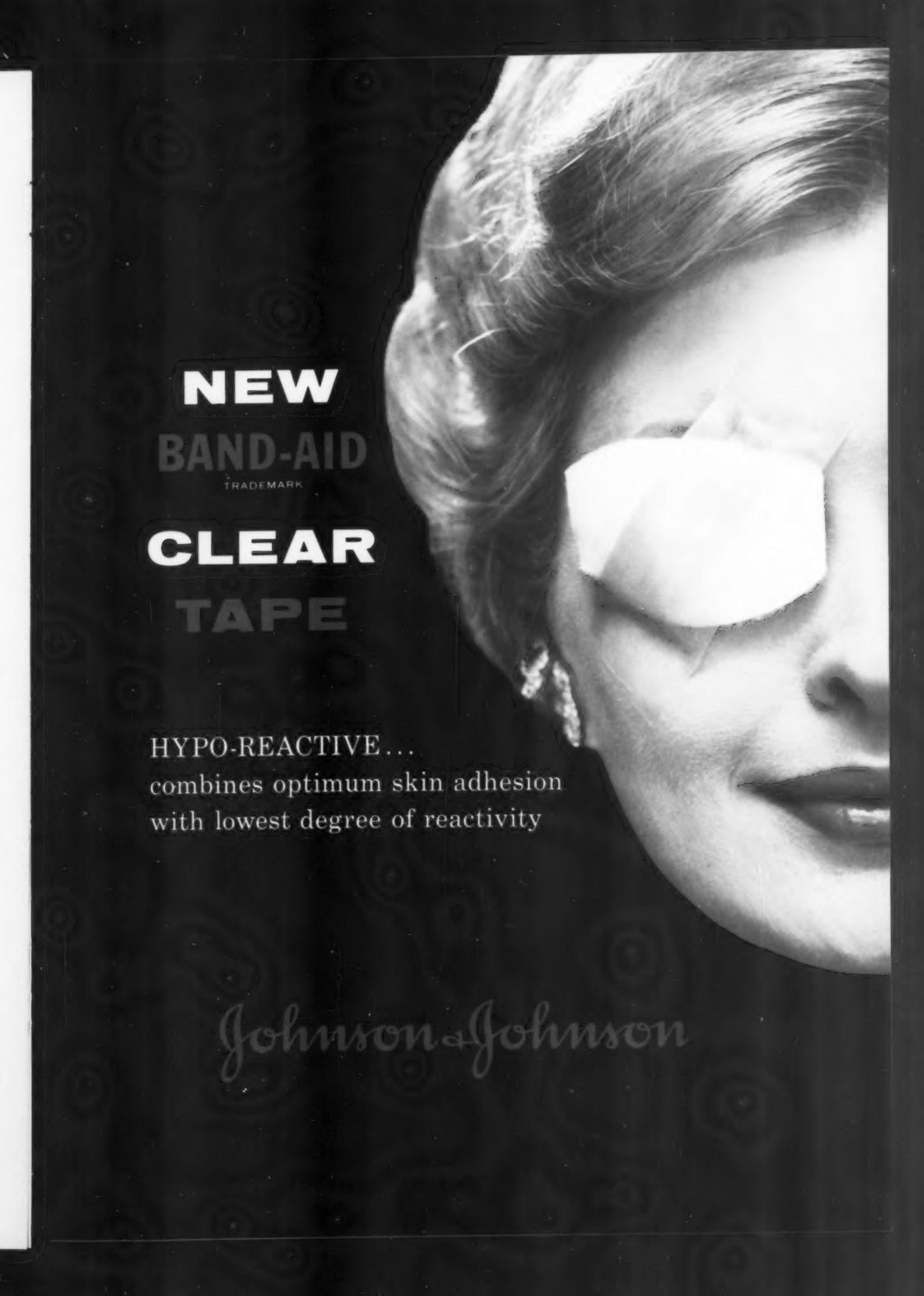
Safety and health factors include a variety of things. Fume hoods for digestion and distillation should be separate from hoods used for organic solvents work. The latter may have steam baths but no gas or electrical outlets. Exhaust ducts from the hood generally should be no less than 8 inches in diameter. Shut-off valves and switches for the hood heaters, lights, steam and electric appliances should be outside of the hood. Fire extinguishers for class A, B and C types of fires must be available in each section. Asbestos or wool blankets should be within easy reach.

Emergency showers usually are specified for the chemistry section, although reversible flow aspirator heads with lengths of hose at each sink may serve. While distilled water lines in each section are favored it is usual for laboratories to have elevated carboys with siphon tubes. The latter is satisfactory if small electric pumps are used to fill the heavy elevated bottles in place. Locked storage must be provided for poisonous reagents, alcohol and so on. Refrigerators, incubators, ovens, water baths, and centrifuges must be located so as not to interfere with the use of free floor space and yet hold travel distance to a minimum for the technologists.

Sanitation and cleanliness are best served by smooth nonporous wall and floor finishes. Floor corners and baseboards should be contoured to permit easy cleaning. Separate lavatories should be provided for patients and staff. Dressing rooms with individual lockers for the staff are essential. Daily clothing changes are recommended for all staff members having contacts with patients.

It appears best to have most service equipment such as centrifuges, water baths, and refrigerators of the movable type. This favors rearrangement to suit varying work loads. Some workbenches also may be movable. Built-in wall cabinets, incubators and refrigerators are not advocated, since obviously they hamper rearrangement that may be necessary. ■

(For floor plans of clinical laboratories for 100 bed and 300 bed hospitals and explanatory text, please turn to pages 146, 148 and 152.)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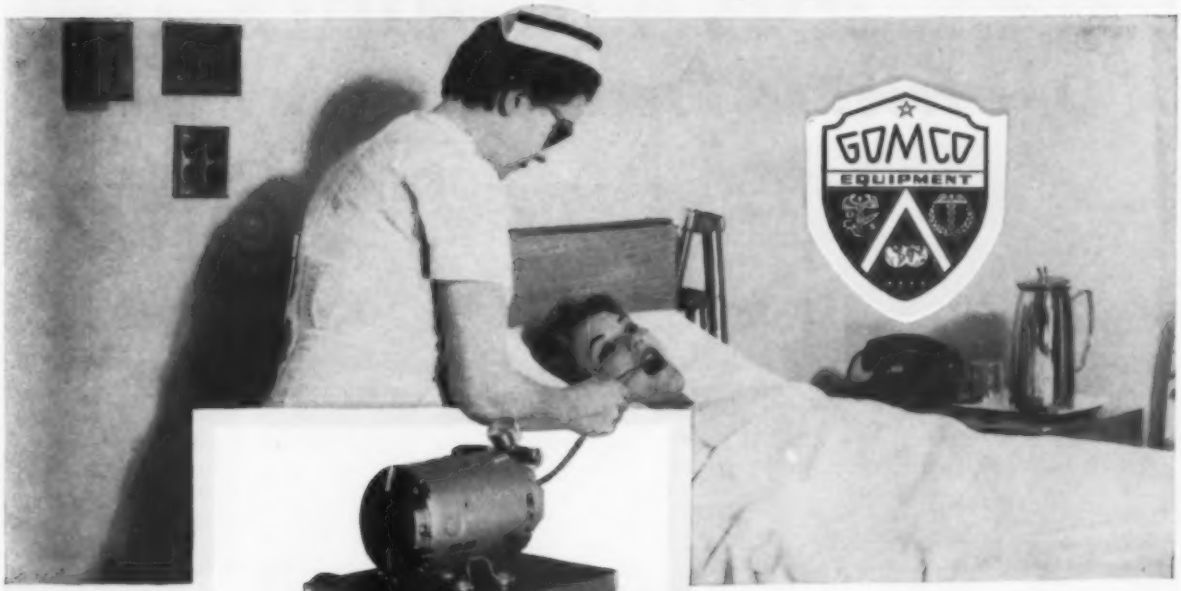

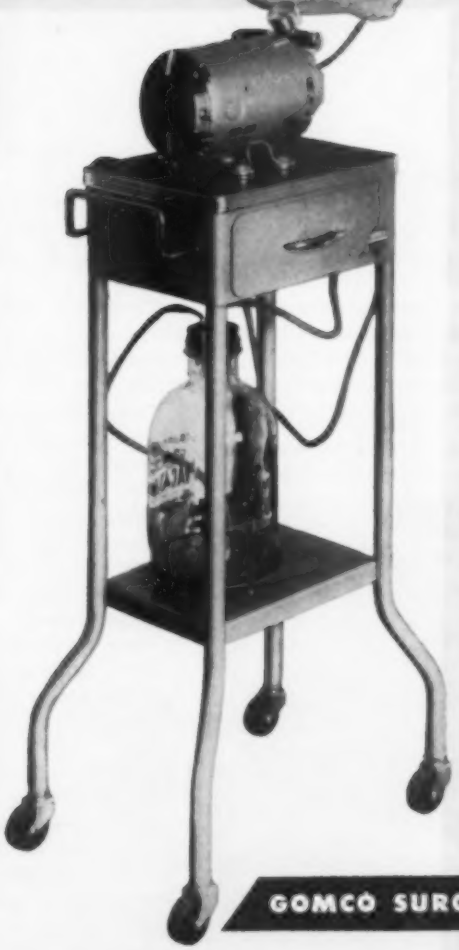

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Freezing Precooked Foods for Use in the Future Saves Time and Money

Doris Zumsteg
Teaneck, N.J.

FAST freezing of precooked foods can afford year-round economies in food and labor costs in many food departments. Not every dietitian will see fit to take advantage of freezing foods in the same way. But well planned utilization of on-premises freezing can be a great help in simplifying the work load.

This article is not aimed at a discussion of frozen foods in general, but of the freezing of certain prepared foods in the kitchen for use on the premises or in decentralized preparation units.

Freezing foods may not be necessary all during the year; it may be practical only in advance of week ends or the busier seasons, during vacations, or in anticipating the need for holiday specialties.

On the other hand, freezing of precooked foods can afford economies in some operations where seasonal foods are cheap, freezer space is on hand or available at reasonable cost, or where the work load is such that the cook can prepare twice as many casseroles at one time during the week, freeze half of them, and have them available for use when the staff is limited over week ends or at night.

Menu variety is improved by food freezing, too. The croquettes made of leftovers need not appear on the menu right away; they can be frozen and used at a more advantageous time. However, for best quality and economical use of freezer space, food freezing should be planned for use within a two to three month period. Many main dishes will not suffer serious quality loss if properly packaged and stored up to six months, but after six months' storage, quality often declines rapidly.[1]

One pound blocks of oyster-clam bisque mix can be made up into two-quart units of soup, as needed. Monosodium glutamate is used to retain the flavor.

Precooked items that may be frozen include:

Chicken: breaded and fried, pies, turnovers, casseroles

Fish: breaded and fried, fish cakes, cutlets

Croquettes: meat, vegetable, fish, cheese

Casseroles: cheese, macaroni, vegetable, fish, meat

Beef, lamb and veal pies

Stews, ragouts, goulashes

Hamburgers, meat balls, meat loaves, "pigs in blankets"

Salads: based on cream or cottage cheese; whipped cream mixtures or gelatin mixtures (a frozen salad recipe should be followed); cut up *cooked* salad ingredients

Many sandwich mixes

Many sandwiches

Baked goods: fruit pies, deep dish pies, cakes, biscuits, rolls, muffins and cookies

Desserts with seasonal fresh fruits

Food should be prepared just as it would be for immediate service with a few minor modifications. If cooked to well done stage before freezing, vegetables and cereal items such as spaghetti, macaroni and rice are likely to be too soft when reheated for serving. They may not taste fresh, either. Seasoning should be on the light, rather than the heavy, side and

[1]U.S. Dept. of Agriculture, Home & Garden Bulletin No. 40

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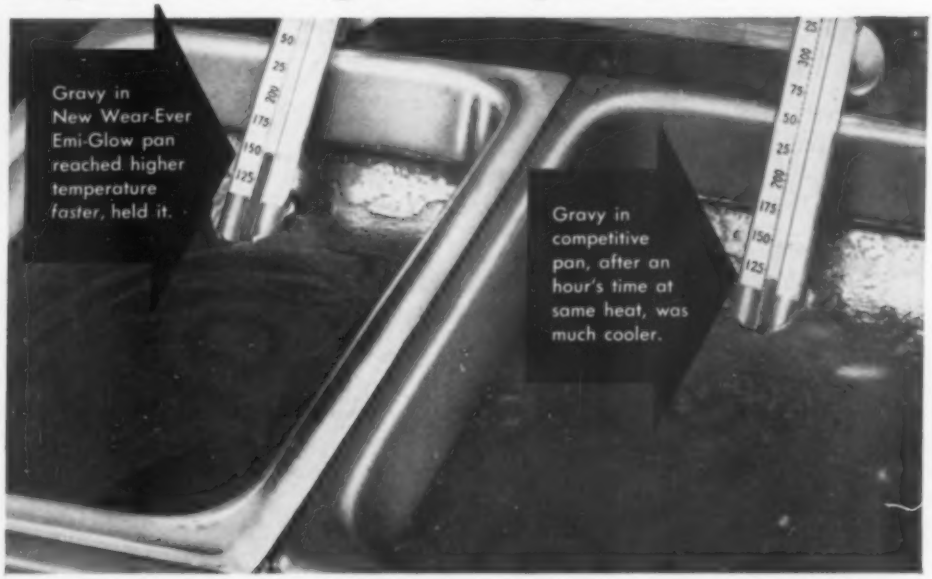

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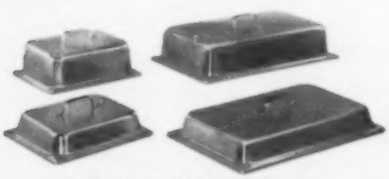

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Basic Meat Mixture for Freezing

Yield: 8 pounds — *Portions: See recipes*

4 pounds beef, chuck, ground
1 quart bread crumbs, fine, dry
2 cups onion, chopped fine
1 teaspoon marjoram
1 teaspoon celery seed
1 quart water
1 1/3 tablespoons salt
1/2 teaspoon pepper
2 teaspoons monosodium glutamate

Method:

(1) Combine ingredients; mix thoroughly but lightly. See the following three variations for sequence of preparation:

Individual Meat Loaves

Portions: 24 5½-ounce individual meat loaves

(2) With No. 8 dipper, place ½ cup mixture into each cup of 24 2-inch muffin pans; round up neatly. (3) Bake in hot oven (400° F.) 15 to 25 minutes (rare to medium). Remove from pans and cool. Wrap loaves in aluminum foil or place in plastic bags to freeze. (4) To serve: defrost and reheat in moderate oven (350° F.) 10 to 15 minutes. Serve plain or with a preferred sauce.

Meat Patties

Portions: 48 2¾-ounce patties; 2 per serving

(2) With No. 16 dipper, divide mixture and shape into patties. Brown quickly on both sides. Place on sheet and finish off in moderate oven (350° F.) 10 to 15 minutes.

Croquettes

Portions: 48 2¾-ounce croquettes; 2 per serving

(2) With No. 16 dipper, portion out mixture and shape into cones, cylinders or rounds. (3) Roll croquettes in fine crumbs, then in diluted egg and again in crumbs. To cook and brown: A. fry in deep, hot fat. B. brush croquettes with melted fat and bake in hot oven. C. brown on hot greased griddle or grill.

Freezer Egg and Nut Cutlets

Yield: 6 quarts — *Portions: 54 cutlets*

1½ cups margarine or shortening
2 cups flour
1½ teaspoons marjoram
1½ teaspoons savory
1 tablespoon salt, to taste
1½ teaspoons monosodium glutamate
2 tablespoons Worcestershire sauce
6 cups milk
15 ounces (3 packages) precooked, packaged rice
2 dozen eggs, hard cooked
1½ quarts nuts, chopped
2¼ cups bread crumbs, fine
6 eggs, beaten
¾ cup milk
¾ cup shortening, for frying

(1) Melt margarine or shortening; stir in flour and seasonings. (2) Remove from heat; gradually stir in milk. Heat to boiling, stirring constantly; boil 1 minute. (3) Cook rice according to package directions for least amount of water. When tender, add to sauce in Step 2, with chopped eggs and nuts. Chill thoroughly.

(4) With No. 16 dipper take up portions and roll in bread crumbs. Shape into cutlets. Coat with combined egg and milk and again with crumbs. Place on baking sheet; freeze until firm. Seal in plastic bags; store in freezer.

(5) To serve: Remove and pan-fry, without thawing, in hot fat until golden on all sides.

the use of pure monosodium glutamate, along with the seasonings, is important for full flavor values, as shown by its wide use in the freezing industry.

Pastry crusts frozen unbaked are more tender, crumblier and have a fresher flavor than pies which are first baked and then frozen. The crust is said to be better browned, too, according to good authority.[2] Pies which are frozen unbaked need not be thawed before being placed in the oven.

Bulk dough that has not been shaped prior to freezing obviously must be thawed before it can be shaped.

Berry pie fillings should be thickened with flour, cornstarch or quick tapioca before the filling is put in the crust to avoid soaking into the dough.

Gelatin and cornstarch "cream" pies, including lemon and chocolate, freeze well, but custard pies cannot be frozen successfully.

Crumb or cheese toppings should not be frozen, but should be added when the pie is baked for serving.

All kinds of cakes freeze well, including angel, sponge and chiffon cakes; so do cupcakes, cookies and rolls; icing should be of the cooked or butter type, not the sort made with egg whites; this does not stand up when frozen.

Rolls can be frozen unbaked or baked. Those frozen unbaked are preferable from the standpoint of odor, flavor, speed of preparation, and general "freshness." However, there is possibility of reduced volume or failure. Partially baked rolls are preferable. Since these are quite readily obtainable from commercial bakeries, it is probable that only extremely large food operations that do their own baking will use freezer space for rolls or bread.

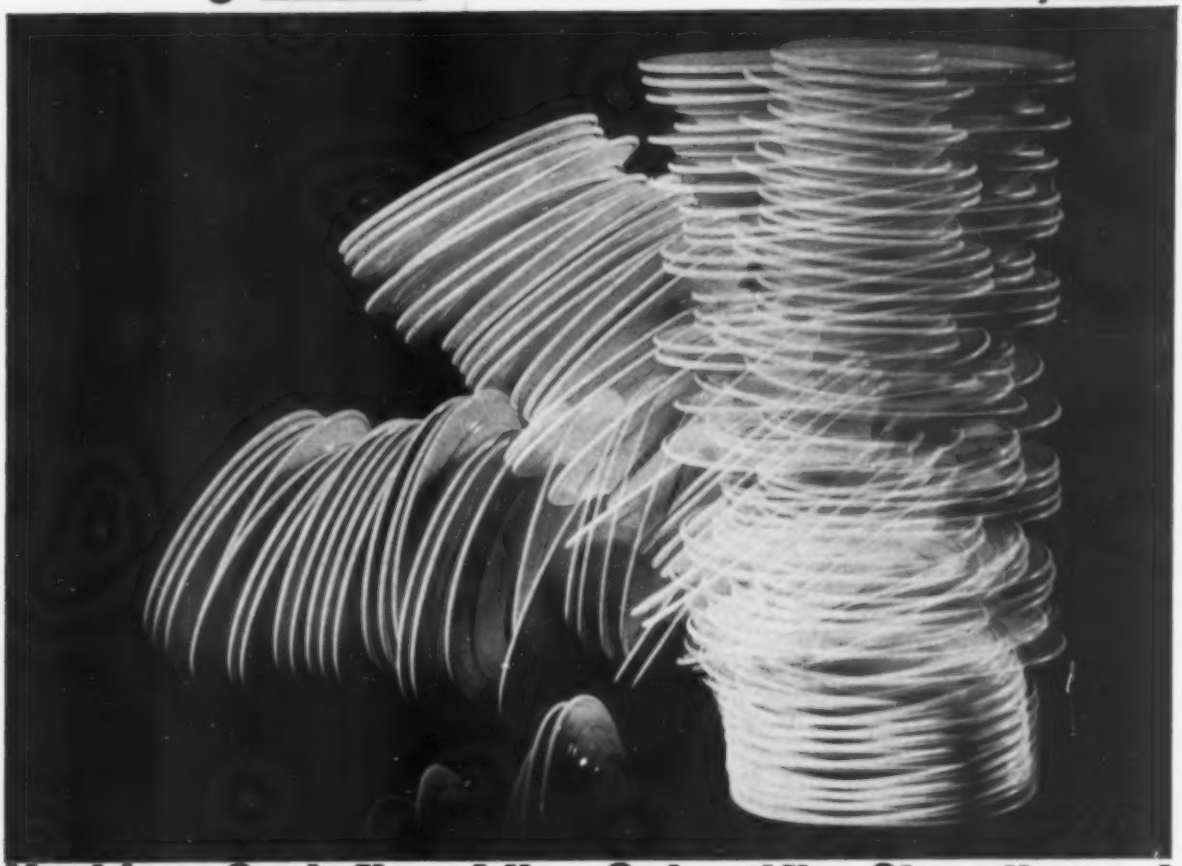
Many popular sandwich fillings freeze well: sliced meat, cheese, cottage cheese, cheese and olive mixture, poultry, meat loaf, peanut butter. One filling that stores well in the freezer is made up of tuna, chopped unblanched almonds, and cooked salad dressing with lemon juice, salt and pepper to taste.

In preparing sandwiches to be frozen, spread the bread with butter or margarine, not mayonnaise, out to the edges to prevent the filling from soaking into the bread.

For thickening sauces and gravies

[2]Tressler, Evers & Evers: Into the Freezer and Out. Avi Publishing Co., 1953

Nothing Costs More than Carelessness



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Basic Oyster-Clam Bisque Mix for Freezing

Yield: 6 pounds — *Portions: 6 1-pound units*

- 2 quarts oysters, canned, drained (save juice)
- 1 cup clams, canned, minced (save juice)
- 3 cups clam and oyster juice
- 2 5-ounce packages precooked rice
- 2 teaspoons salt
- 1 teaspoon monosodium glutamate
- 1 cup butter or margarine

Drain oysters and clams thoroughly. Measure liquid. Add water, if necessary, to make 3 cups. Chop oysters and clams. Heat clam and oyster juice to boiling. Add rice, salt and monosodium glutamate. Stir once to wet all the rice. Remove from heat; cover and let stand 10 minutes. Put mixture in electric mixer. Whip at high speed to smooth paste. Add oysters and clams, butter or margarine.

To freeze: Line 13 by 4 by 4 inch loaf pan with heavy duty aluminum foil with ends extending to expedite removal of contents. Spread mixture evenly. Cover with foil. Freeze. When frozen, turn out of pan, cut into six 2 1/3 inch blocks. (They will be 1 pound each.) Wrap in 16 inch squares of foil and store in freezer until ready to use.

To Prepare Bisque

Yield: 2 quarts — *Portions: 10 6-ounce servings*

- 1 quart milk
- 1 pint light cream
- 1 1-pound block of basic mix
- 1/4 cup parsley, minced
- 1 tablespoon paprika, optional
- 1/3 cup sherry, optional

Heat milk and cream in top of double boiler. Add basic mix without thawing. Heat through. Just before serving, stir in parsley, or paprika, and sherry.

for frozen casseroles, sliced meat dinners, and so on, special thickening agents known as waxy rice flour or waxy corn flour, if available, are preferable to wheat flour.[3]

Quick cooling of the cooked food is essential, since it stops the further cooking process and aids retention of flavor and color. The usual principle of cooling food uncovered prevails in this case as well.

Packaging

No matter what foods are being fast-frozen, certain basic concepts are involved. There should be as little air in the package as possible in order to prevent drying out and loss of flavor. Packaging must be of moisture-vapor-proof or moisture-vapor-resistant material. Waxed paper, ice cream containers, or cardboard containers such as those in which cottage cheese is packed are not sufficiently vapor-proof.

According to Tressler and Evers, a special polyester film "is believed to be the strongest of all plastic films" and is unaffected by even the abrupt shift

[3]Tressler & Evers,: The Freezing, Preparation of Foods, Vol II, p. 185, Avi Publishing Co., 1957

FREE

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from freezer storage to boiling water.[4] This individual portion pack is under considerable research by some manufacturers and may prove practical for on-premises freezing.

Food should be packaged in units of practical size. Mixes should not be frozen in huge containers if the normal need is for 5 or 10 pounds at a time. Once the food is defrosted, it should not be frozen again – and this fact should be firmly impressed on food handlers; the urge is very strong to toss some leftover defrosted food back into the freezer when space is handy.

Prepared foods such as meat pies, deep dish dessert pies, and casseroles may be frozen in the containers in which they were baked and will eventually be reheated and served. Aside from the usual pottery casseroles or nappies, light, attractive aluminum foil round and oblong containers of varying sizes are available for all baking and freezing needs. Some have tops while others require the use of moisture-vapor-resistant transparent or freezer foil, which comes in sheets.

Liquid or semiliquid concoctions are best packed in rigid covered freezer containers. These are available in various sizes and in materials ranging from glass to plastic.

Polyester bags are suitable for such items as croquettes or other items which hold their shape. As much air as possible is forced out of the bag and tight closure made by folding back the edge and securing with a rubber band or plastic band.

Foods packed in pliable bags can be packed in cardboard cartons for protection and easy stacking.

Complete main courses, including meat with gravy, vegetables and potatoes, may be frozen in the aluminum foil compartment trays. These meals, like frozen sandwiches, are a boon to the decentralized kitchen operation in the hospital.

The dietitian who intends to freeze precooked foods to any extent should look over the freezer containers and materials thoroughly. The right tools will mean improved products, lowered costs, and a really effective portion control.

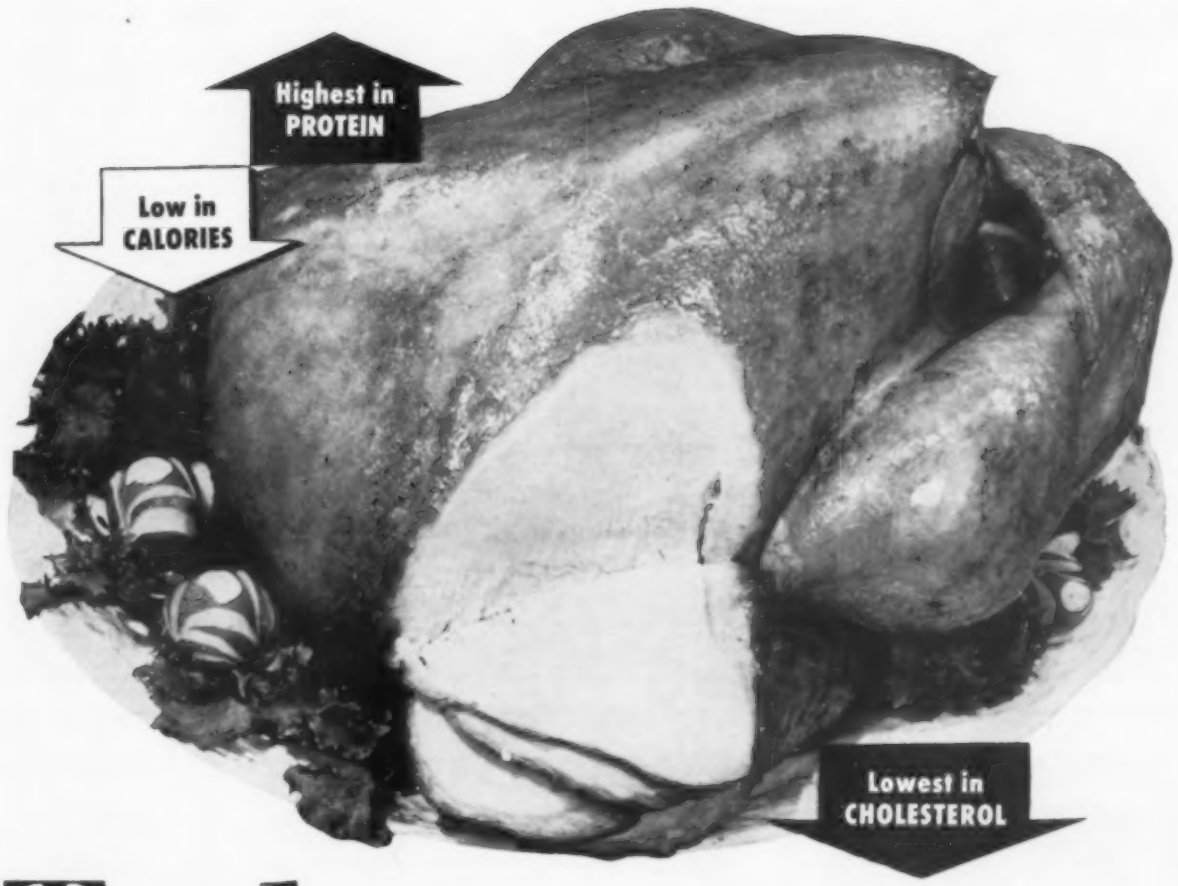
Storage Temperature

In general, the lower the temperature at which frozen foods are stored, the longer they may be kept and the better the color, flavor and nutritional value will be. Zero is the highest point at which frozen foods should be stored. At 0° F. the losses are very slow, but at 10° F. or above the loss is much more rapid, with rancidity and off-flavors resulting in the food within a short time.

Do not attempt to freeze:

1. Most mixtures containing mayonnaise.
2. Jelly or jam sandwiches.
3. Lettuce or chopped raw vegetables, such as celery, radishes, pepper, coleslaw.
4. Frostings prepared with egg white or meringue topped pies.
5. Coffee cream. Cream containing 40 per cent or more butter-fat can be frozen without too much deterioration, but it is not smooth when defrosted. Whipped cream, however, can be frozen successfully.
6. Do not use ordinary waxed paper or household weight foil for freezing. Use heavy-duty foil. Use sealing tape – some of the self-sealing wrappings which are self-sealing at room temperature become rather brittle in the freezer.

[4]Tressler and Evers: The Freezing Preservation of Foods. Vol. II, p. 56, Avi Publishing Co., 1957



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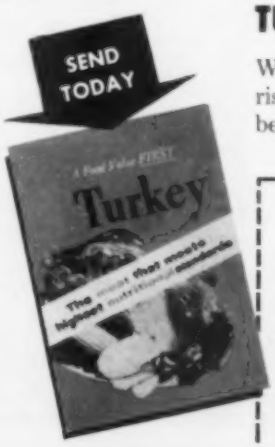

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Menus for October 1958

Clair B. Kusch
Dietitian
Memorial Hospital
St. Joseph, Mich.

1 Blended Juice Scrambled Eggs • Baked Spare Ribs Creamed Potatoes Green Beans Lettuce Salad With Sliced Tomato Cherry Tarts • Cream of Mushroom Soup Hot Meat Loaf Sandwich Mixed Vegetables Cream Cheese and Pear Salad Cookies, Orange Sherbet	**2** Grapefruit Hot Roll • Stuffed Veal Birds Browned Potatoes Cauliflower Carrot, Raisin and Nut Salad White Cake, Icing • Cream of Tomato Soup Chicken a la King on Biscuits Buttered Peas Relishes Fruit Gelatin, Cream	**3** Orange Juice Hot Muffins, Jelly • Baked Whitefish, Lemon Parsley Buttered Potato Harvard Beets Head Lettuce Salad Blueberry Pie • Vegetarian Vegetable Soup Tuna Fish Sandwich Relishes Potato Chips Bing Cherries, Cookies	**4** Prunes Coffee Cake • Chop Suey Crisp Noodles, Rice Banana and Peanut Butter Salad Coconut Cream Pie • Cream of Chicken Soup Hamburger on Bun Citrus Fruit Salad White Cake, Icing	**5** Grape Juice Poached Egg, Bacon • Roast Beef Mashed Potatoes Buttered Peas Sliced Orange and Coconut Salad Pineapple Pudding • Vegetable Beef Soup Toasted Cheese Sandwich Molded Fruit Salad Date Cake, Whipped Cream	**6** Grapefruit Sections Hot Roll • Calves' Liver, Onions Browned Potatoes Whole Kernel Corn Lettuce Salad, French Dressing Peach Pie • Split Pea Soup Baked Frankfurters Stuffed With Rice and Bacon Asparagus Tossed Salad Apricots, Cookies
7 Grape Juice Hot Muffins • Oven Fried Chicken Mashed Potatoes Buttered Peas Pear and Nut Salad Boysenberry Pie • Orange Juice Beef Stew Cauliflower Lettuce With Grated Cheese Cupcake	**8** Applesauce Scrambled Eggs, Bacon • Ham Loaf Candied Yams Broccoli Tossed Salad Strawberry and Rhubarb Pie • Beef Noodle Soup Meat Roll, Mushroom Sauce Buttered Peas Molded Orange Salad Tapioca Pudding	**9** Apple Juice Hot Sweet Rolls • Leg of Lamb, Mint Jelly Riced Potatoes Stewed Tomatoes Molded Vegetable Salad Cake Roll • Orange Juice Creamed Dried Beef and Eggs on Noodles Asparagus Spears Banana and Peanut Butter Salad Apple Betty	**10** Apricots Coffee Cake • Broiled Pike Parsley Buttered Potato Buttered Beets Cabbage Slaw Lemon Pie • Tomato Soup Toasted Cheese Sandwich Fruit Salad Potato Chips Pickles, Olives Baked Custard	**11** Sliced Oranges Hot Muffin • Beef Pot Pie Baked Potato Buttered Spinach Tossed Salad Apple Pie, Cheese • Cream of Chicken Soup Barbecued Hamburger on Bun French Fried Potatoes Relishes Chocolate Pudding	**12** Tomato Juice Poached Egg, Bacon • Roast Pork Mashed Potatoes Buttered Asparagus Molded Orange and Grapefruit Salad Pecan Pie • Vegetable Soup Hot Potato Salad Rolled Cold Cuts Spiced Fruit, Relishes Applesauce Cake
13 Grape Juice Coffee Cake • Spanish Beef Patties Escalloped Potatoes Baked Squash Tossed Salad Cherry Pie • Apple Juice Baked Noodle Casserole Green Beans Peach, Grapefruit, Raisin Salad Bread Pudding	**14** Orange Juice Hot Muffins • Corned Beef Parsley Buttered Potato Boiled Cabbage Cottage Cheese, Fruit Salad Pumpkin Pie With Whipped Cream • Beef Noodle Soup Toasted Ham and Cheese Sandwich, Pickle Sticks Potato Chips Fresh Fruit Salad Tapioca Pudding, Cookies	**15** Grapefruit Scrambled Eggs, Bacon • Roast Veal Mashed Potatoes Stewed Tomatoes Spiced Fruit Tossed Salad Banana Cream Pie • Pineapple Juice Chicken Roll With Mushroom Sauce Brussels Sprouts Relishes Cupcake With Icing	**16** Apple Juice Hot Rolls • Breaded Pork Tenderloin Creamed Potatoes Green Beans Sliced Tomato Salad Blueberry Tarts • Chicken Rice Soup Swiss Steak Glazed Carrots Orange and Apple Salad Chocolate Brownie, Ice Cream	**17** Orange Juice Baked Egg • Broiled Haddock, Lemon Butter Baked Potato Buttered Beets Coleslaw Lemon Chiffon Pie • Vegetable Soup Creamed Tuna on Biscuits Green Lima Beans Stuffed Celery Sticks Spiced Fruit Gingerbread With Whipped Cream	**18** Applesauce Hot Muffins • City Chicken Browned Potatoes Escalloped Corn Tossed Salad Strawberry Pie • Grapefruit Juice Ham With Escalloped Potatoes Spinach Lettuce Salad, Roquefort Dressing Butter Cookies
19 Orange Juice Poached Egg, Bacon • Roast Chicken, Dressing Mashed Potatoes Asparagus Molded Fruit Salad Apple Pie, Cheese • Beef Noodle Soup Creamed Dried Beef and Eggs on Toast Buttered Peas Endive With Vinegar and Oil Dressing Royal Anne Cherries	**20** Grapefruit Juice Coffee Cake • Braised Short Ribs Escalloped Potatoes Brussels Sprouts Cheese and Fruit Salad on Watercress Custard Pie • Cream of Tomato Soup Chicken Sandwich Potato Chips Lettuce Salad With Tomato Wedge Banana Cake	**21** Pineapple Juice Hot Muffins • Cabbage Rolls Browned Potatoes Peas Orange and Coconut Salad Chocolate Pie • Bouillon, Croutons Macaroni Loaf Baked Sausage Asparagus Relishes Apricot Whip	**22** Grapefruit Juice Soft Cooked Egg • Broiled Lamb Shoulder Chops au Gratin Potatoes Broccoli With Hollandaise Sauce Sliced Tomato Salad Coconut Cream Pie • Split Pea Soup Chicken Croquette With Mushroom Sauce Baked Potato Tossed Salad Melon Balls	**23** Apricots Scrambled Eggs • Roast Pork, Dressing Browned Potatoes Spinach With Lemon Head Lettuce Salad, French Dressing Boysenberry Pie • Celery Soup Cheese Omelet Canadian Bacon Molded Citrus Salad on Watercress Cream Puff	**24** Grapefruit French Toast, Sirup • Salmon Loaf, Cheese Sauce Parsley Buttered Potato Brussels Sprouts Tossed Salad With 1000 Island Dressing Peach Cobbler • Vegetable Soup Shrimp Creole Rice Green Beans Orange and Apple Salad Angel Food Cake
25 Apricot Nectar Sweet Rolls • Liver and Bacon Browned Potatoes Buttered Peas Waldorf Salad Raisin Pie • Tomato Juice Hot Roast Beef Sandwich Wax Beans Lettuce and Grated Cheese Salad, With Vinegar and Oil Glorified Rice	**26** Grape Juice Poached Eggs, Bacon • Roast Turkey, Dressing Mashed Potatoes Asparagus Spears Cranberry, Orange Salad Pumpkin Pie, Cream • French Onion Soup Spaghetti and Meat Balls Cabbage Slaw With Celery Seed Dressing Apple Betty	**27** Cantaloupe Baked Eggs, Muffins • Roast Beef Riced Potatoes Glazed Carrots Lettuce and Tomato Salad Pineapple Cream Pie • Consomme, Croutons Creamed Ham and Egg on Biscuits Buttered Peas Endive Salad Citrus Fruit Cup	**28** Blended Juice Cinnamon Toast • Stuffed Pork Chops Baked Potato Spanish Green Beans Cream Cheese and Grapefruit Salad Blueberry Pie • Tomato Juice Turkey Hash Broccoli Spears Relishes Chocolate Fudge Cake	**29** Sliced Oranges Scrambled Eggs, Bacon • Cube Steaks Mashed Potatoes Whole Kernel Corn Tossed Salad With 1000 Island Dressing Cherry Pie • Lima Bean Soup Hot Baked Ham Sandwich Potato Chips Sliced Cucumbers, Cream Dressing Apricot Whip Cookies	**30** Grapefruit Poached Egg • Roast Leg of Lamb, Chopped Mint Browned Potatoes Peas and Carrots Combination Fruit Salad on Watercress Lemon Pie • Vegetable Juice Sauteed Chicken Giblets on Noodles Spinach Stuffed Celery, Olives Pineapple Cake, Cream

31 Sliced Oranges, Sweet Roll • Fish Sticks, Stuffed Baked Potato, Baked Acorn Squash With Grated Egg, Lettuce With Vinegar and Oil, Apple Pie, Cheese • Cream of Mushroom Soup, Tuna Fish Salad, Hot Corn Bread, Relishes, Boston Cream Pie.

Ready-to-eat or cooked cereal served on all breakfast menus.

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The benefits are easy to recognize. The ice is 100% pure and untouched, meeting rigid sanitary standards for all hospital uses . . . bedside drinking water, ice bags, food service, as well as therapeutic needs. Scotsman ice does not need to be carried . . . each machine is located where the ice is used. And since Scotsman crushed ice costs only 7¢ to 10¢ per 100 lbs., they can use all the ice they want.

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For additional information, use postcard on page 279.

This Method Makes It Possible To Keep Oxygen Canopies Clean

James W. Cooke

DESPITE the recent advances in machines for cleaning equipment such as syringes, needles, solution flasks, and rubber gloves, there is not, so far as I know, one that will clean an oxygen tent canopy properly. At the Akron City Hospital, Akron, Ohio, we attempted to solve this problem and are now cleaning oxygen tent canopies in an efficient, labor saving manner.

Oxygen tent canopies are available today in two forms: the expendable type and the semipermanent type. We have been using the semipermanent type of canopy for a number of years.

Each canopy that has been used by a patient in isolation is, of course, immediately destroyed after use. All canopies that have been removed from patients who have died are thoroughly cleaned routinely in our oxygen storage room. Oxygen tent canopies that have been removed from all other types of patients are thoroughly inspected to determine whether they need to be cleaned. If the canopy is not soiled, it is simply wiped off with a damp rag to remove accumulated dust and put back into use.

Oxygen tent canopies that must be thoroughly cleaned are first removed from the canopy frame and immersed completely in a lukewarm solution of soap and water. All zipper fasteners of the canopy are opened, and the canopy is left to soak for two to three minutes. The canopy is scrubbed inside and out with a small hand brush while immersed in this solution of soap and water.

A built-in bath tub is located off the floor at such a height that the employe does not have to bend over the tub to clean the canopy (Fig. 1). The built-in tub also is a convenient container for our washing solution, since it is adequate in size and prevents water from being splashed on the floor. After the canopy has been scrubbed, the water is drained from the bathtub.

The canopy is then attached to a mock canopy frame and pulled up by a rope and pulley arrangement (Fig. 2). It is sprayed with tap water by means of a shower head attached to the end of a rubber hose. The canopy must be sprayed thoroughly in order to remove the soil and soapy water.

Next, the tub is refilled with approximately 5 to 10 gallons of water—just enough to cover a collapsed canopy completely. To this water is added 4 to 5 ounces of sequestrating agent (water softener). The oxygen tent canopy is immersed in this final rinse water for a few minutes — 5 minutes at the most — and then it is pulled back up by the rope and left to dry (Fig. 3).

The sequestrating agent is added to the final rinse water to decrease the surface tension of the water. When this is done, the water drains off the canopy almost completely, eliminating water spotting on the canopy during the drying process. A patient who must spend the entire day looking out through an oxygen tent speckled with water spots can become extremely annoyed by its hazy appearance.

The results we have attained over the years with this cleaning operation have been most gratifying. Employes do not seem to mind cleaning oxygen tent canopies since the method is labor saving and more convenient for them. This cleaning method also fulfills the manufacturers' purpose in fabricating a semipermanent canopy. These canopies are made to withstand months of wear if they are cleaned properly and handled carefully. ■

Mr. Cooke is assistant executive director of Akron City Hospital, Akron, Ohio.

Fig. 1: Employe need not bend over to wash canopy in built-in bath tub.

Fig. 2: Canopy is attached to this frame, raised by rope and pulley.

Fig. 3: After final rinse, canopy is pulled up again, then left until dry.

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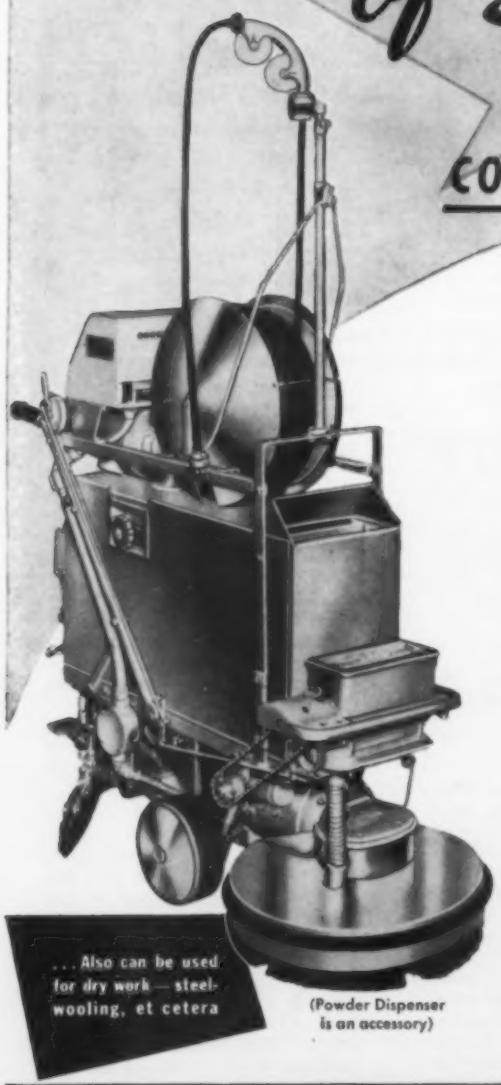

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(Powder Dispenser is an accessory)

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Finnell makes *Scrubber-Vac Machines* for small, vast, and intermediate operations, and in *gasoline* or *propane powered* as well as *electric* models. From this complete line, you can choose the size and model that's exactly right for *your* job (no need to *over-buy* or *under-buy*). It's also good to know that *a Finnell Floor Specialist and Engineer is nearby* to help train your maintenance operators in the proper use of the machine and to make periodic check-ups. For demonstration, consultation, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1409 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

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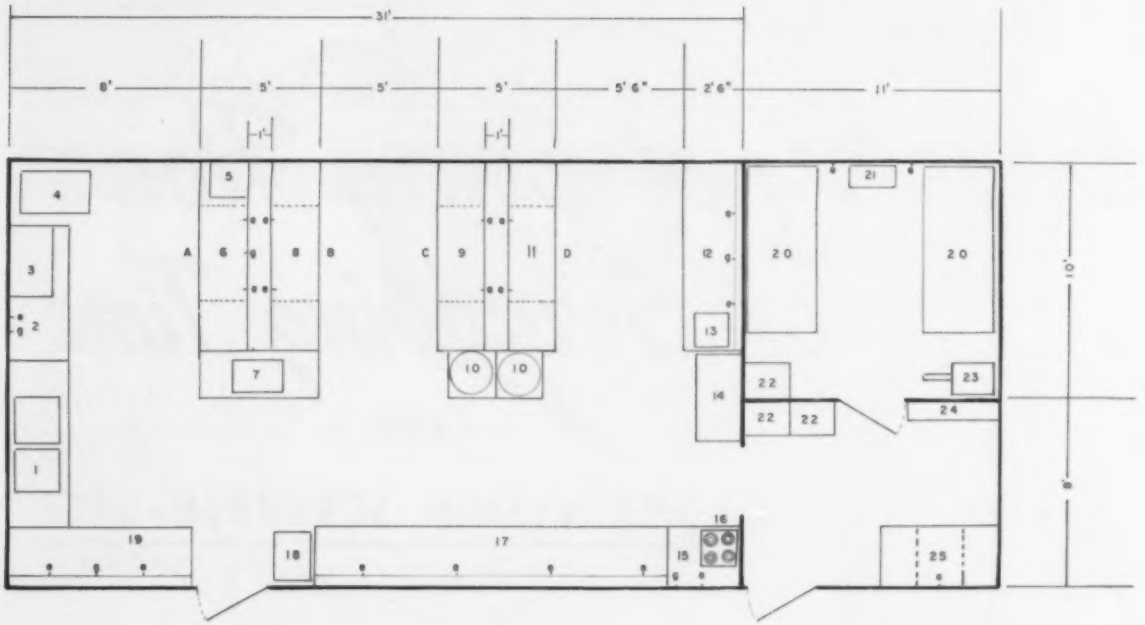
HOW TO PLAN THE LABORATORY FOR A 100 BED GENERAL HOSPITAL

Seward E. Owen, E. P. Finch and W. H. Byers



Suggested layout of a laboratory for a 100 bed general hospital. Explanation of figures and letters shown on drawing is given in accompanying running text.

Clean-Up Area

1. Double bowl, double drainboard, stainless steel with cupboard storage space below. 7 inch over-all width, 36 inches high.
2. Stainless steel counter top over base drawer units, 36 inches high, 6 feet wide, and 30 inches deep. There is no step shelf on this unit.
3. Hot air oven used to dry glassware and dry sterilization.
4. Autoclave steam sterilizer equipped with a shut-off valve on the exhaust so that Loeffler's and TB culture media can be sterilized at low temperatures using steam and air mixtures in the chamber.

Bacteriology Section

5. Small bacteriological 37° C. incubator.
6. Bench units 30 inches high. Laminated plastic counter top is 8 feet long by 24 inches deep in front of a 6 by 6 inch step shelf which carries gas and electrical outlets. The knee space at "A" is 4 feet wide and made by fastening a two-drawer unit table rail between two, 2 foot base units. One of these base units should be a cupboard type to hold microscopes, the other a drawer type for test tubes, and so on. (This space at "A" could be narrowed to 3 feet, with a single drawer in the rail section, if one of the base units was enlarged to 3 feet instead of 2 feet.)
7. Stainless steel cabinet type sink 5 feet wide, single bowl, double drainboard 30 inches high. This sink will be used for staining procedures and washing blood pipettes from hematology section.

Hematology Section

8. This entire unit is a duplicate of that just described under No. 6 and "A" above. Knee space here at "B" is similar to "A" above and "C" and "D" later.
9. Units here are similar to those described under No. 6 above. Knee space at "C" similar to "A."
10. Centrifuge on mobile base.

Serology and Transfusion

11. Units here are similar to those described under No. 6 above. Knee space at "D" similar to "A."

Histology Section

12. Bench units here are 36 inches high. Top is 8 feet long by 24 inches deep. Step shelf 6 by 6 inches runs along back of unit along wall. Base units are composed of three 2 foot drawer units and the sink is placed in a 2 foot cabinet section.
13. Stainless steel sink set into laminated plastic table top.
14. Double door refrigerator, 30 cubic feet. This box serves for the entire laboratory and should be equipped with thermostats of alarm type to warn personnel of power failure or temperature changes greater than plus or minus 3° C. One side of this box is used for the transfusion section.

Chemistry Section

15. Hood for digestion procedures in chemistry section.
16. Steam bath with rings for evaporation procedures. One hole of the bath must be large enough to take a circular rack approximately 6 inches in diameter. This rack holds tubes used for heating solutions used in the determination of blood and urine sugar, blood urea, and so on.
17. Bench unit 15 feet long by 24 inches wide, a 6 by 6 inch step shelf runs from hood to end of counter. Counters are 36 inches high. Base units composed of drawer sections and an occasional cupboard unit.
18. Stainless steel mobile laboratory cart for glassware and miscellaneous hauling jobs around the laboratory.

Urinalysis Section

19. Counter top here is 8 feet long by 24 inches deep. A 6 by 6 inch step shelf runs along the rear of this bench. Drawer bases, one 3 feet wide and the other 2 feet wide, support the top. Laminated plastic top extends to wall. Space between sink and base closed by paneling corner. Note: All counter tops in this laboratory are black laminated plastic except that at No. 2, which is stainless steel.

31 feet of metal wall cupboard storage space is provided as follows: wall cabinets 4 feet high with glazed sliding doors, adjustable shelves, and shielded fluorescent lighting on underside of cabinet for bench top illumination. 8 feet wide along wall

For additional information, use postcard on page 279.

behind bench area No. 12; 15 feet along bench area No. 17; and 8 feet over the urinalysis bench at area No. 19. Cabinets are mounted 12 inches above step shelf (18 inches above counter top).

Blood Donor and Basal Metabolism Room

20. Two beds for basal metabolism tests in the early morning. These beds may also be used for electrocardiogram tests and for drawing blood from donors for transfusion section.
21. Small table holding equipment needed in this room. In place of this table, a wall storage assembly may be used, probably to better advantage. Three adjustable shelves covered by glazed sliding doors are provided in the upper section of this case. One side of the base is composed of four drawers; the other side is a cupboard and drawer combination with the drawer on top. Total dimensions are width 49 by 84 inches in height, by 23 inches deep. Metal. Upper section is 4 feet high.
22. Clothing locker.
23. Basal metabolism machine. If extra space is needed for clothing lockers, one may be placed in this area and the basal machine stored elsewhere.

Pathology Office

24. Storage or filing unit for blocks and slides for the pathologist.
25. Pathologist's desk.

Electrical Connections

Electrical outlets are shown as "E." Those required for centrifuges, incubators and so on are not shown. Hot air oven at No. 3 should be 220 volts.

Gas

Gas outlets marked "G" on drawing.

Pressure

Not needed in the laboratory.

Suction

Suction is provided at sinks No. 7 and No. 13 by means of a hydroaspirator with a built-in vacuum breaker. The aspirator is attached to its own cold water line and is equipped with a faucet type shut-off valve.

HOW TO PLAN THE LABORATORY FOR A 300 BED GENERAL HOSPITAL

Histology

1, 2, and 3 bench units 36 inches high. 24 inch knee hole spaces at 1, 2, and 3 made by fastening a 24 inch unit table rail between two bench units. The number of drawers and cupboard base units depends upon the wishes of the pathologist. Steel wall cupboards, 4 feet high with glazed sliding doors, hang on the walls and fill the area over counters 1, 2 and 3. Fluorescent lighting fixtures are fastened on the underside of these wall units for bench top illumination. The paraffin embedding oven and automatic tissue processor have not been shown on the drawing. The use and position of these pieces of equipment, again, depends upon the pathologist's wishes. If used, they would probably interfere with the wall cabinets; consequently, the wall area over base marked 1 should remain clear except for a thermostat mounted over the oven and tissue processor to serve as a fire alarm.

4—Stainless steel cabinet sink, 4 feet wide with drainboard mounted on left side.

Pathology Office

5—Examining room 8 feet from door to back by 6 feet wide. This room could be made from temporary partitions similar to those used in large offices. Some pathologists would prefer not to have an examining room; if that is the case, the partitions could be removed and stored for future use.

Bleeding Room (6)

Probably more correctly named "Specimen Collection Room." Equipment here is standard waiting room furniture. Clinic and ambulatory house patients report here for specimen collection. Secretary, by means of a buzzer, or intercom system, calls appropriate technician from across the hall. The outside wall of this room (area A) will hold five 2 foot wide clothing lockers for male technicians.

Toilets, Men and Women (7)

Washroom facilities here should be for the use of laboratory personnel only. Areas for specimen collection from patients should be provided in clinics and on the wards.

Suggested layout of a laboratory for a 300 bed general hospital. Explanation of figures and letters shown on drawing is given in accompanying running text.

B.M.R. and Blood Donor Room

8—In the early morning hours, this room is used for basal metabolism tests. During the day and evening, blood is drawn from donors for use in the hospital blood bank. The rear of this room, area "B," will hold five clothing lockers, 2 feet wide, for female employes.

Clean-Up Room

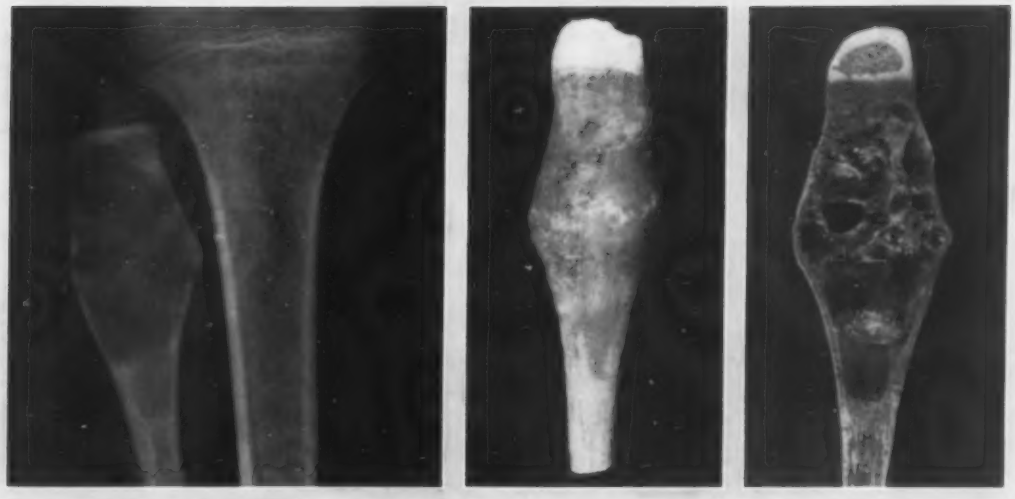
9—Cabinet type sink, double bowl, double drainboard, stainless steel. A third faucet is provided at the sink, operated by a foot valve, for demineralized water rinse for glassware. Demineralizing units sit under the drainboards of the sink.

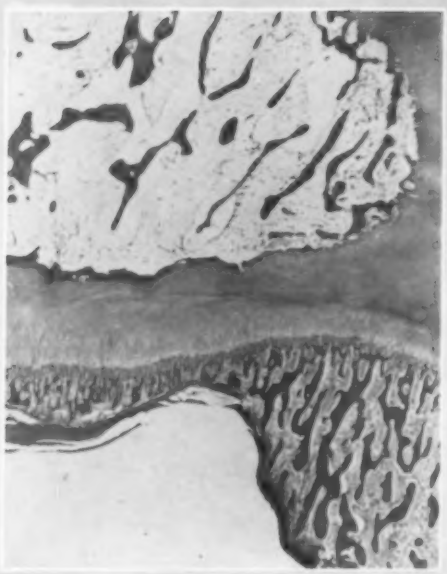
10—Stainless steel counter top, 36 inches high. Drawer storage underneath. 4 feet high. Wall cupboard storage, steel, with glazed sliding doors and fluorescent lighting (shielded) on the underside of units as in histology. Areas covered with these units, wall to wall, are at 10, 11, and 15.

11—36 inch high drawer and cupboard storage units; 24 inch knee space, 4 feet from door at "C."

12—Hot air sterilizing oven on its own cabinet type base.

13—Autoclave, at least 3 feet in depth. Outside should be covered with insulating material to eliminate excessive heat in the room. (*Continued on Page* 152)





BONE CYST . . . 4 aspects

Radiograph *(upper left)* of bone cyst of the fibula. The lesion has its characteristic location in the end of the shaft and does not transgress the plate.

Photograph *(upper center)* of external surface of upper end of fibula resected because of the presence of a bone cyst. The contour of the cystic area is expanded, and two healed fracture lines are to be noted.

Photograph *(upper right)* of transected specimen showing the lesion illustrated above, center. The cyst cavity contains considerable organizing blood, which was present because of recent fracture.

Photomicrograph (x 3) *(left)* showing topography of the fibular cyst. From above down, one notes epiphysis, epiphyseal cartilage plate, and cyst wall abutting upon the metaphyseal spongiosa and plate area.

For data on Nonossifying Fibroma, turn page.

For Staff Meetings, Teaching, Research

...both radiography and photography are needed

Radiography for diagnosis, for case study and review; photography—to show what attending physician, surgeon, and pathologist saw. Both are essential to modern medical records.

Of itself, each is important; together, they complete the picture . . . provide material for discussion and review—for teaching and research . . . help extend the boundaries of medical education—today, tomorrow, years from now.

What is the cost of material such as this? Surprisingly small, considering the value of the fully documented case records.

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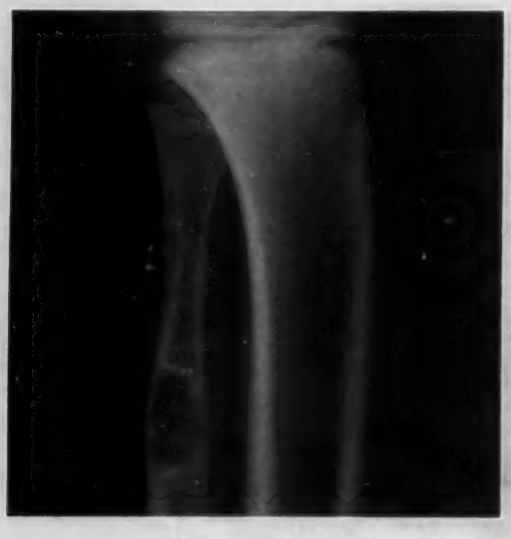
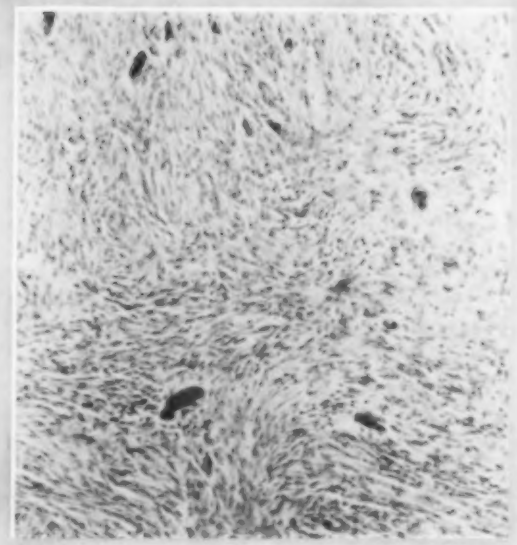


NONOSSIFYING FIBROMA . . .
3 aspects

Radiograph *(upper left)* of a nonossifying fibroma in the shaft of a fibula of a boy of 8 years. The lesional area appears somewhat loculated.

Photograph *(upper right)* of segment of fibula (cut longitudinally) containing the lesion shown in the preceding radiograph.

Photomicrograph (x 15) *(right)* showing the general pattern characteristic of the lesional tissue of nonossifying fibroma. The stromal cells are spindle-shaped and whorled, and intermingled with small numbers of giant cells.



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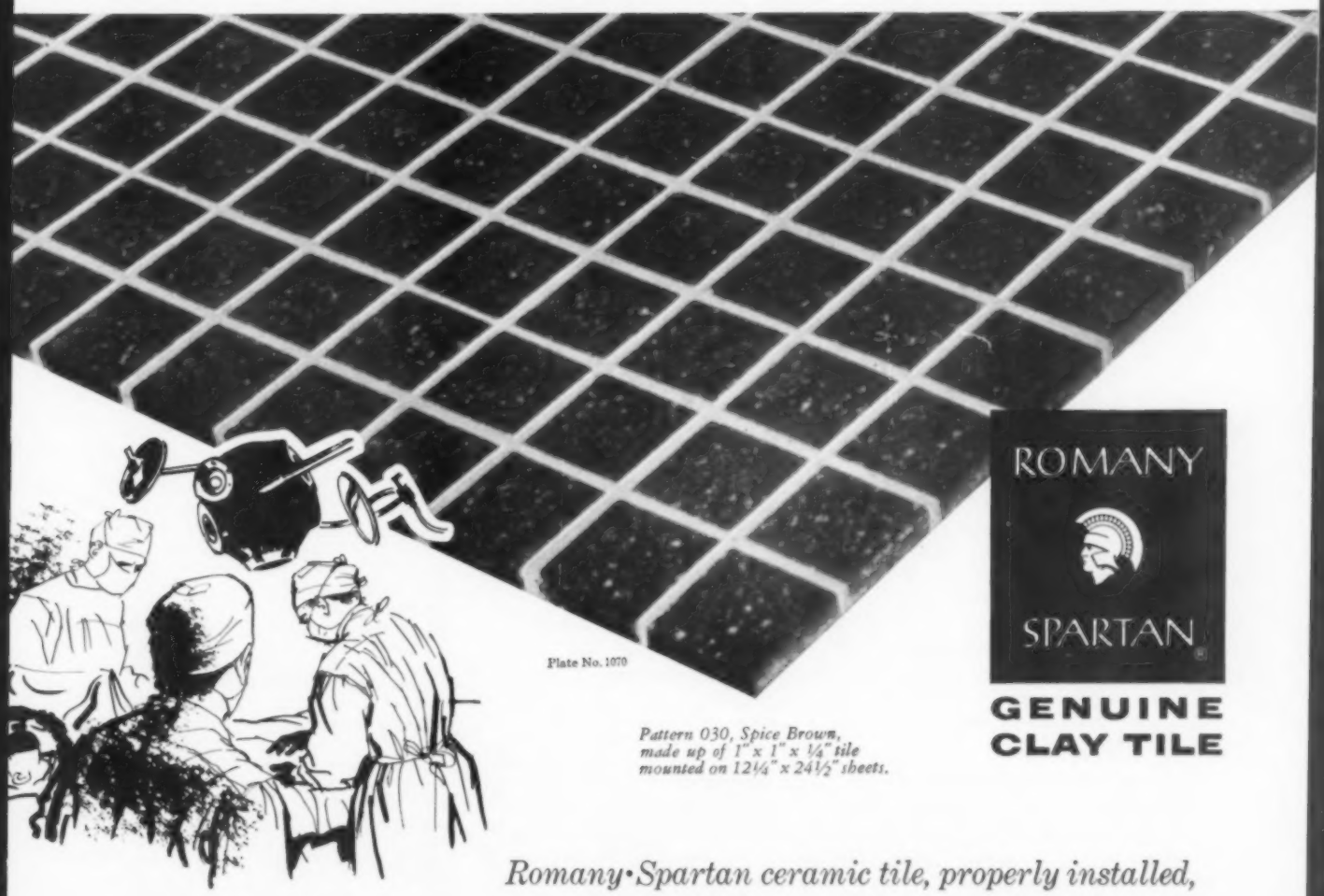

Plate No. 1070

Pattern 030, Spice Brown, made up of 1" x 1" x ¼" tile mounted on 12¼" x 24½" sheets.

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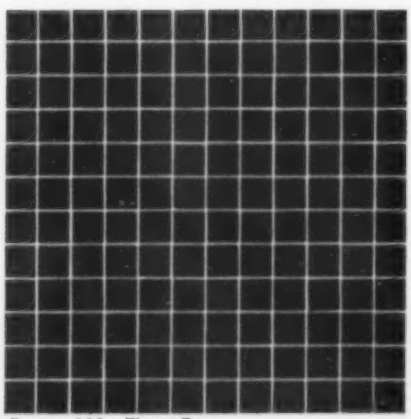

Pattern 030 – Taupe Brown

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14—36 inch high drawer unit. This unit is approximately 2 feet square and should have a stainless steel top.
15- 36 inch high bench unit of drawer and cupboard storage. Knee space should be provided at "D," 24 inches wide. An electric hot plate, used along bench 15 for preparation of culture media isn't shown on drawing. It is extremely important that adequate ventilation be provided in this room. Two large transom type fans should be installed near the ceiling to make certain that steam from the autoclave, hot air from the oven, and unpleasant odors from the autoclave are promptly removed from the area.

Bacteriology and Serology

16—Centrifuge.
17—Refrigerator for serology and bacteriology. 20 cubic feet, double door opening in center.
18—Two bacteriological incubators, stacked one on top of the other.
18a—Bench units 4 feet wide with stainless steel top. Drawer storage below.
19—Bench units, 30 inches high and 3 feet wide, with drawer and cupboard storage space. Knee spaces, 24 inches wide at "E."
20—30 inch high counter with drawer and cupboard storage space below.
21—Cabinet type sink, stainless steel, drainboard on left, 36 inches high.
22—Bench units, 30 inches high, 3 feet wide, drawer and cupboard storage. 24 inch knee spaces at "F," "G" and "H." Metal wall storage cabinets 4 feet high with glazed sliding doors and fluorescent shielded lights on the under surface to provide bench top illumination. These units are mounted on walls over counters 19, 20 and 22.

Bank and Hematology

23—36 inch high bench unit with drawer and cupboard storage space below.
24—Blood transfusion section refrigerator. Either circular type or a refrigerator made especially for blood storage, equipped with alarm type thermostats responding to a temperature fluctuation of more than 5° C. (A left-hand hinged door will be necessary if this refrigerator is placed at the other end of bench 23.)
25—Bench unit 30 inches high with 4 foot wide drawer and cupboard storage space. Knee space, 36 inches at "J."
26—Centrifuge.
27—Drawer unit, 24 inches square, with stainless steel top, 36 inches high.
28—Stainless steel, cabinet type sink and drainboard (sink on right).
29—Bench units, 24 inches wide and 30 inches high, with knee spaces (24 inches) at "K," "L," "M" and "N." Wall storage metal cabinets with glazed sliding doors and shaded fluorescent lighting on under surface for bench top illumination. Mounted on wall areas over benches 23, 25 and 29.

Chemistry

30—Two wall storage cabinets, metal, with adjustable shelves, glazed sliding doors, 84 inches high by 70 inches wide. For chemical and reagent storage.
31—Refrigerator. Top shelf opens into hall so that night urines may be placed inside and refrigerated. Full door with left-hand hinge on laboratory side.
32—36 inch counter with drawer and cupboard space below, as desired. Knee space at "P" 3 feet wide and 4 feet from hood (33). This is the urinalysis section.
33—Hood containing steam bath (steam coils) with one set of rings large enough to admit a 6 inch diameter circular rack holding test tubes for boiling procedures in chemistry and urinalysis (sugars). A cup sink and gooseneck faucet are in rear.
34—Center island type worktable 36 inches high, 4 feet wide by 6 feet long. Made of two 3 foot base units on each side placed back to back. One of the 36 inch cabinet units on a side should contain 2 shallow pipette drawers (half high —3⅜ inches high by approximately 16 inches wide), 3 regular drawers, 6¾ inches high by approx. 16 inches wide, and two full width drawers 6¾ inches high by approximately 33 inches wide. The other unit on the same side of the island should consist of a drawer-cupboard unit. One side should contain a cupboard with adjustable shelf, the other side composed of four drawers 6¾ inches high by approximately 16 inches wide. The opposite side of the island is composed of units identical to those described above.
35—Double drainboard stainless steel sink, cabinet type, 36 inches high.
36—Centrifuge.
37—Bench units, 30 inches high with knee spaces at "Q" cupboards and drawer storage space below. One of the base units should be a desk pedestal type of cabinet equipped with three drawers and pull-out shelf. Bottom drawer is letter size with adjustable compressor. Wall cabinets are placed along walls over counters 32 and 37. Glazed sliding doors and fluorescent lights on under surface for bench top illumination as in other rooms.
Note: Counter tops, unless specifically stated to be stainless steel, are black laminated plastic. Toe space 4 inches high by 3 inches deep is provided on all base units. Wall cabinets mounted above bench units have adjustable shelves and extend along the entire wall over benches mentioned.

Electrical Outlets

Shown on drawing as a small **e**. Those required for incubators, and so on, are not shown. In the hematology room, along bench 29, a plug-in strip might be more desirable than ordinary receptacles. In fact, these receptacles should have 4 female plugs instead of the ordinary 2.

Suction

Suction is provided at the following sinks —4, 9, 21, 28 and 35—by means of an extra cold water faucet equipped with an aspirator of the type commonly used by undertaking establishments for embalming procedures. This type of water pump is equipped with a vacuum breaker, thus protecting the water supply from contamination.

Pressure

Is not needed anywhere in the laboratory.

Gas

Outlets shown on drawing as small **g**.

For additional information, use postcard on page 279.

Efficient Planning Comes Out in the Wash

Some 30,000 pounds of linen processed weekly, without undue strain on employes or machines, testify to the careful planning that went into this remodeled laundry

Delfin Savillo

WHEN plans for a separate unit to house the maintenance shops for St. Francis Hospital, Evanston, Ill., were announced, the Sisters of St. Francis felt they could be proud of the preparatory planning which had taken years.

The architects, Gaul and Voosen of Chicago, with Leo Lynk, the hospital's chief engineer, had completed an intricate arrangement for combining the hospital's small laundry building with the new construction in such a way as to make the laundry routine more efficient. The new building would also house carpenter shop, paint shop, other repair workshops, and boilers and coal loaders.

Work started on remodeling of the laundry machinery. Every piece that could be reconstructed so that it would perform just as the newest equipment could was retained. Any piece that could not be modified was discarded. In addition, $50,000 worth of new machinery was purchased.

Now, entirely refinished, with modern, labor saving, high production mechanism, the new laundry assures the ultimate in efficiency with minimum operating personnel. Maximum capacity per square foot of floor space was obtained when former obsolescent machines were refinished or replaced with modern, automatic equipment.

Here 28,000 to 30,000 pounds of wash are handled weekly. This includes all the linens in the patients' rooms, draperies, bed screen covers, gowns, linens for surgery and for x-ray, and uniforms of student nurses and interns and residents.

The washer room contains large new sorting bins, designed by Mr. Lynk, and constructed by his workers, to hold soiled linens of every kind. They are done in neutral gray that harmonizes with the gleaming stainless steel washers and other moss-green colored fixtures and equipment in the laundry.

Soiled linens are brought from the chutes throughout the hospital on trucks. They are then taken to the sorters who toss the linens into the conveniently located bins from which they can be loaded into the automatically controlled washers.

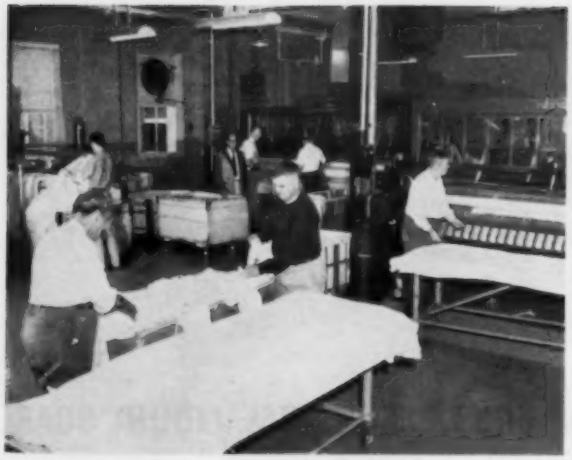
In this room, an old, small washer was replaced by a large, brand new model in silvery stainless steel. This machine stands in line with two other unloading washers, with full automatic controls installed between them. These controls automatically inject soap and water, and regulate bath levels and temperature, as well as time and change of baths. They eliminate 59 separate manual operations.

(*Continued on Page* 156)

Mr. Savillo is the laundry supervisor of St. Francis Hospital, Evanston, Ill.

Sorters and washers. Soiled linens are brought to the sorters from chutes and are tossed into bins from which they can be unloaded into automatic washing machine.

Dryer room. Linens are transferred from washers into extractors by hoists on overhead rails. Some linen is dried in the tumblers while the remainder goes to the ironers.



Ironer room. The ironer room is brightly lighted both by sunlight and by fluorescent fixtures. From the large ironer, pieces go to an automatic folder, then to conveyor.

Conveyor. Only one receiving operator is needed at the ironer to cross-fold and stack the sheets, and put them on the conveyor that takes them to the distribution center.

Loads of linen are then transferred from the washers into two extractors by push-button operated hoists, traveling on overhead rails. A battery of four tumblers receives some of the moist linen for drying, while others are hoisted over the chute and dropped to the ironer room below.

In the ironer room fluorescent lights add to the sunlight that streams in through the venetian blind covered windows.

Off this room is the men's locker room where easy chairs, tables, literature, and soft drink vending machines bring comfort to the weary worker during rest periods.

The extracted flatwork, which has been conveyed via chute from the washer room above, is tossed onto the feed conveyor for the conditioning machine that eliminates the manual "shake-out" operation, thus increasing production and eliminating employe fatigue.

Small pieces, such as towels, pillow cases, and patients' gowns, are emptied from the conditioner into trucks and taken to the six roll ironer.

All the ironers are equipped with ventilating canopies. Sheets and large pieces of linen are trucked to a sheet spreader that enables one operator to do the work of two or more in smoothing out each piece for the ironer. The sheets are then taken to the second, eight-roll ironer.

At the delivery end of the large-piece ironer, linens are automatically quarter-folded, after which they need only be cross-folded and stacked. With the automatic folder, only one receiving operator is needed at the ironer to cross-fold and stack the sheets, as well as place them on the conveyor to the linen distribution center.

The pressing room is attractive with ivory and twilight gray tiled walls. There are four sets of pressers; one is new and three were moved from the old laundry.

Stainless steel topped counters and folding tables, practical and good looking, improve the workers' efficiency. There are also folder-sorting bin units which prevent mix-ups and reduce labor. Uniform racks, another product of the maintenance crew, are mounted on casters so that it is easy to transfer them to the nurses' residence when uniforms are delivered.

The linen distribution center was designed to eliminate time consuming guesswork and the errors of "do it yourself" delivery. Here rows upon rows of snowy white linen, carried in on the conveyor from the ironer room, are sorted and then trucked to the various departments. ■

Pressing room. There are four sets of pressers. Uniform racks built by the maintenance crew are mounted on casters for ease of transportation to the nurses' home.

Linen distribution room, with rows of clean linen stacked on shelves, is guaranteed to delight the eye of any laundry supervisor. From here linen is trucked to other areas.

For additional information, use postcard on page 279.

Ground Rules for People Who Make the Policies

(*Continued From Page* 88)

officer may depart from that policy, either in certain prescribed conditions or upon his own discretion, in each case either temporarily or perhaps, indeed, permanently. This matter of departure from policy should always be quite clear-cut and clearly understood by all who have an interest in the policy. It should never be a matter for conjecture and, in general, policy should be like the law, certain and definite in its application and alterable only according to certain quite clear and well defined rules.

Finally, some reference should be made to the difficulties which constantly arise because of uncertainty in the minds of some people as to the difference between policy and degree. Frequently, matters are quoted as questions of policy and principle when they are, in effect, nothing of the kind. To buy item X because it is cheaper than item Y is not a matter of policy; that is a matter of degree. There might, indeed, be a general policy to buy everything in the cheapest market, but that is another matter. The importance of this concept is that administrators and governing bodies are constantly being urged to alter *policies* when, in fact, it is not policies which are involved, but the implementation of those policies.

As we have already seen that there are wider policies and narrower policies and that, so to speak, one man's policy is another man's action, we should not attempt to take this matter too far, but it is undeniable that there is a distinction between a matter of policy, on the one hand, and a matter of degree or implementation, on the other hand, and that there is a tendency to mistake the latter for the former. If, for example, a hospital has a long waiting list for patients awaiting general surgical operations, it is most unlikely that the solution lies in the policy making of the governing body, and it is much more likely that the solution is in the hands of those managing the day-to-day affairs of the hospital. The hospital does not need to alter its policy: It needs to improve its methods.

To summarize, then, policy formulation and planning should be practical, relevant and consistent. It should not be too rigid or too detailed, and it should be based upon fact and not upon assumption. ■

NEWS DIGEST

University of Washington Will Reduce Hours of Study in Nursing Course . . . Joint Commission Outlines Responsibilities of Infections Committee . . . New Jersey Group Studies Hospital, Blue Cross Costs . . . Iowa Student Wins Ball Award

University of Washington Will Reduce Hours of Study in Nurse Training Course

SEATTLE. — A five-year curriculum-research project at the University of Washington School of Nursing has resulted in recommendations for sweeping changes in the course of study there.

Most significant finding, according to Dean Mary S. Tschudin, is that "the quality of nurse training is not tied to the number of days a student spends, but to the strength of the educational program."

In accordance with this, the university will make substantial reductions in its course of study for training nurses. A major change will bring a shorter work week in the students' clinical years.

An experimental "three-year" training program which the university has used for a small part of its student nurses over the last five years will be discontinued, however.

The nursing faculty reached its decision after hearing final reports from the study which began in 1952 with grants from the National Institutes of Health and the Commonwealth Foundation totaling $230,513 to support the investigation.

Final details of the curriculum will not be settled until the coming school year. Students entering this month (September) will take courses reflecting some of the basic changes, however.

Under the new program, students seeking a bachelor of science degree in nursing will take 13 quarters of work, instead of 17 as in the past. This will provide them with a degree in four school years and one summer, instead of four years and five summers, as in the past. All new students will now take the 13 quarter course.

Time spent "on wards" in hospitals will be reduced from 30 hours a week to 15 hours, under more intensive teaching supervision.

Instead of taking all their clinical work in one hospital, students will be rotated through several hospitals affiliated with the school of nursing.

Hours spent each week during the clinical training will be considerably shortened. In the past a student has been "on wards" or in classrooms 44 hours a week, studying an additional 18 to 20 hours. Under the new schedule, the nurse typically will spend a total of 45 hours a week "on wards," in class and studying. The new total is approximately that spent by other university students taking a full-time course, Dean Tschudin said.

Introductory courses in nursing will be added to the first year's basic study program to help students who are undecided on a choice of nursing as a career to obtain a better idea of the subject before going further.

Nursing students will pay regular university tuition for all quarters. In the past, students have been required to earn maintenance and tuition the last two years by services to the hospital.

Another change will permit nursing students to live in any approved women's quarters at the university. They may continue to use nursing halls if they prefer.

(*Continued on Page* 195)

Iowa Student Receives Otho Ball Memorial Award

CHICAGO. — Edward J. Miller has been named recipient of the Otho Ball Memorial Fund Postgraduate Training Award, given annually by the American College of Hospital Administrators. Mr. Miller, who received his graduate degree in hospital administration from the University of Iowa, will serve his extended residency at University Hospital, Iowa City, where he has spent the last year.

State Health Department Coordinates Program To Fight Infections

LANSING, MICH. — The Michigan Department of Health has developed a seven-point plan for services within the department to use in assisting hospitals with infection problems, it was announced last month.

Participating in the investigation and control of infections are the division of disease control, records and statistics; the division of maternal and child health, and the division of laboratories.

The department plan has been set up as follows:

1. The first visit to follow up a request for consultation on a suspected hospital infection problem will be made by the chief of the acute communicable disease section, or his designated representative.

2. Since each situation is likely to differ, the procedure to be followed will be determined at the time of the first visit.

3. Other department personnel involved will be directly responsible to the physician in charge (chief of the section of acute communicable disease) and available on his request.

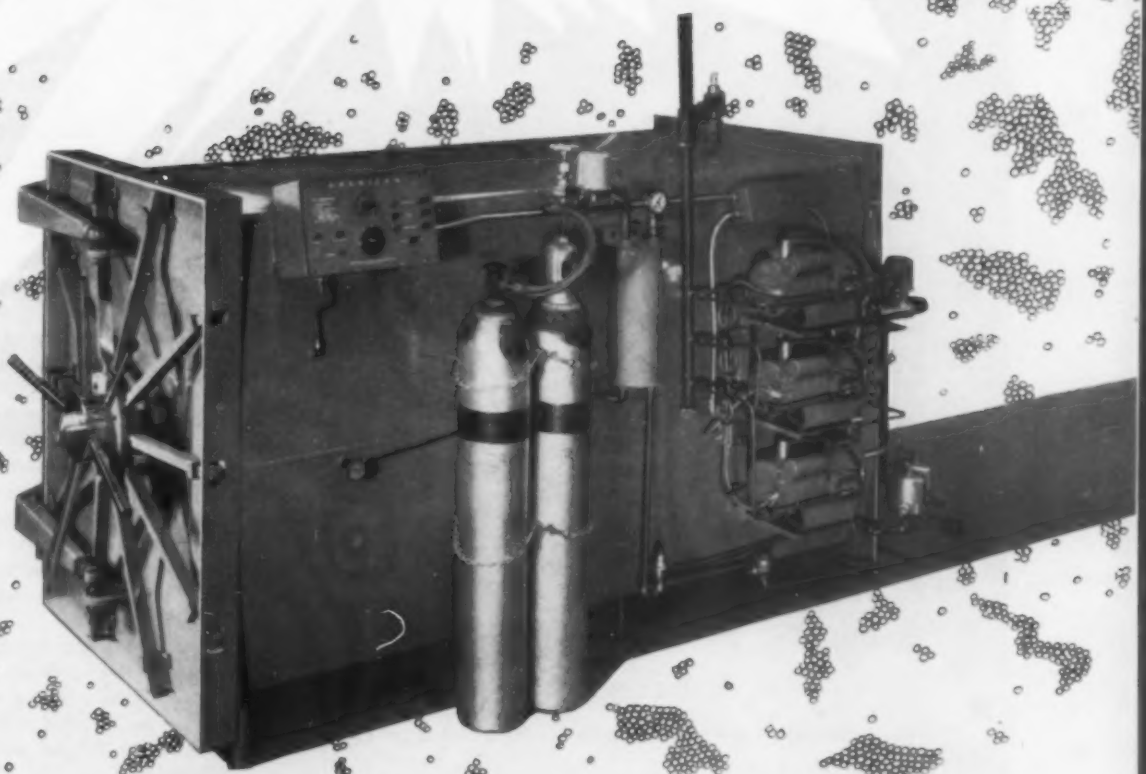
4. All reports, findings and recommendations will clear through the physician in charge (see No. 3) before release.

5. The physician in charge (see No. 3) will keep all interested persons involved informed as early as is convenient.

6. Requests will be honored from both the hospital and the local health department. If the request originates with the hospital, the local health department will be informed.

7. All releases of information to the public will ordinarily be the sole responsibility of the hospital adminstrator. Exceptions to this policy will be made only by the state health commissioner.

A *NEW* WEAPON IN THE WAR AGAINST STAPH!



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N. J. Group Studies Hospital Costs and Blue Cross; State Cuts Blue Shield Rates

TRENTON, N.J. — A citizens committee to study rising costs of hospital care and the effect of such increases on Blue Cross subscription rates has been appointed in New Jersey, it was announced last month by Charles R. Howell, state commissioner of banking and insurance.

Purpose of the committee is to hold Blue Cross rates within the ability of subscribers to pay, it was reported. Members of the group are Sidney L. Simon, associate professor of economics at Rutgers University; Mrs. Grace Hopkins, former president of the New Jersey League of Women Voters, and Harry W. Jones, vice president of the Mutual Benefit Life Insurance Company, Newark. No funds have been appropriated for the study, but several graduate students will be assigned to the project, according to the New Jersey Hospital Association *Reporter*.

Commissioner Howell has asked the committee to give all interested groups an opportunity to present their views to the members. Pertinent material in his department is being made available to the committee, he said.

A request for such a committee was made last February by representatives of labor attending a public hearing on Blue Cross' application for a rate increase.

Similar studies currently are being carried out in Michigan, which has a grant from the Kellogg Foundation for this purpose; in New York by Columbia University in behalf of the state insurance plans, which are paying for the study, and in Pennsylvania, where the governor has appointed a committee of 43 citizens with the commissioner of insurance acting as chairman.

A six-month study of the financial and rate structure of Blue Shield in New Jersey has resulted in a order from Commissioner Howell that Blue Shield reduce its subscriber rates 5 per cent by October 1.

The decrease, which will reduce subscriber premiums by $1.5 million, is to remain effective one year.

Commissioner Howell noted that the organization had "an unnecessarily high" cash reserve of about $10 million, and that its rates were "more than adequate."

According to the *New York Times*, the commissioner also implied that the 5500 physicians participating in New Jersey Blue Shield are entitled to more remuneration than they now are receiving from such insurance. He stressed that his action should in no way interfere with such an adjustment, the report said.

Blue Shield subscription rates were raised three years ago. Blue Cross was granted an 18.5 per cent increase in rates on March 19, 1958, and an increase of 17 per cent in November 1956.

Tribute to Hospitals

CHICAGO. — A tribute to hospitals and the American Hospital Association was paid by Alex Dreier, NBC radio commentator, on August 17, immediately preceding the 60th convention of the association.

Tracing the history of hospitals, the program pointed out the number of specialists and amount of equipment needed to keep thousands of hospitals running, and touched on the hospital-hotel comparison of operating costs.

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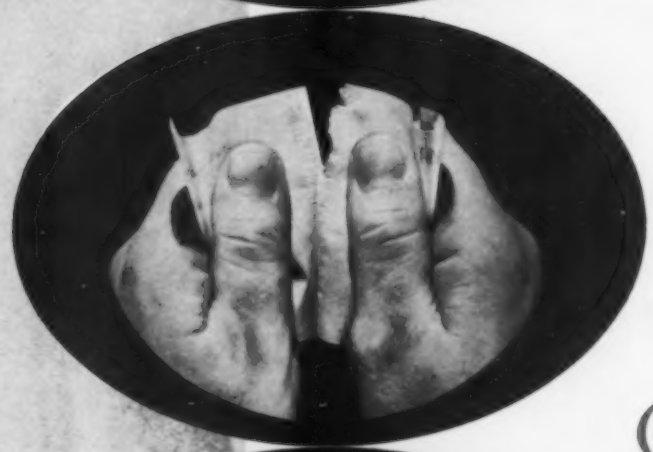

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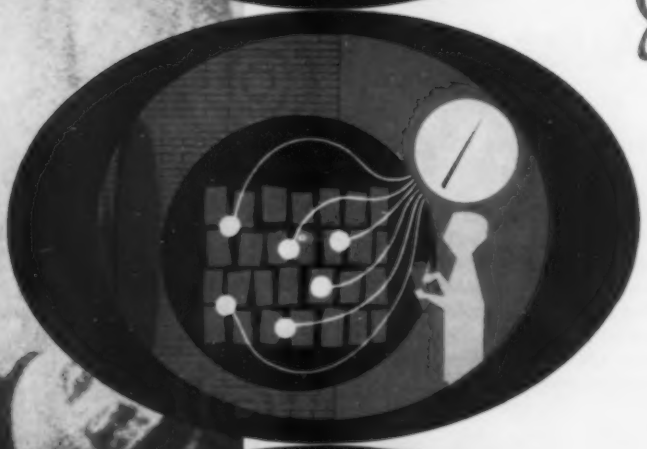
Johnson & Johnson



No guesswork — Johnson & Johnson autoclaves are equipped with heat recording thermocouples that test temperatures right in the autoclave — in the package — in the dressing.

A sterility test is performed on each sterilizing load. Absence of positive cultures verifies the sterility of the load.

Better Counseling, Financial Aid Needed To Attract Students, Chicago Report Says

CHICAGO. — An improved system of counseling in the hospital administration field and increased financial support for students would do much to increase the number of applicants to hospital administration programs, it was stated in a report issued last month by the graduate program in hospital administration at the University of Chicago.

Ray E. Brown, director, and Sophie V. Zimmerman, coordinator of the graduate program, conducted a student selection project to determine why so many persons inquired once about the hospital administration course and then did not apply after they were sent a course catalog. During 1956-57, 379 persons wrote for information, but 211 were not heard from again.

A questionnaire sent to these 211 people was returned by 91, and their answers were divided into factors related to the Chicago course and factors having to do with graduate training for hospital administration in general.

For the most part, the report said, factors listed by respondents as influencing their decision not to apply to the University of Chicago were matters of basic policy and philosophy of the university and its graduate hospital administration program, and, as such, were not those which might be changed.

Deterrents listed under "other" on the questionnaire included: classes too small; application fee (which is $5); wanted evening classes; wanted to take only courses directly on subject of hospitals, and the graduate test for business administration. A fee of $10 is charged for this test, which was not felt by the school to be a financial obstacle to serious students; a lack of understanding of the test was believed to be the most important factor here. To remedy this, the program is now considering including a description of the test or a copy of the testing booklet with the catalog it now sends to those who inquire.

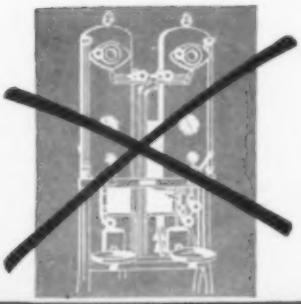
To Study Catalog

The program's catalog also will be studied to be sure that it clarifies those points that might be confusing or lack clarity. Although only 2 of the 91 respondents stated the catalog did not give enough information, the report said, nevertheless, answers to other questions indicated that there was not full understanding of the graduate program's content and underlying philosophy.

Several of those who did not seek further information from the University of Chicago had applied and were accepted for hospital administration training at other universities, it was reported.

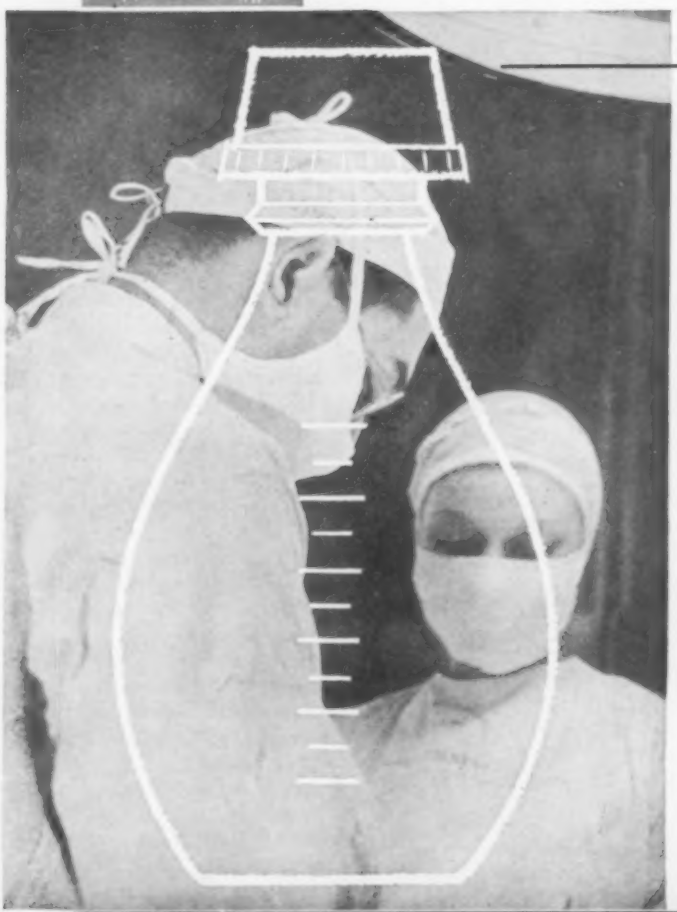
Personal factors listed as influencing respondents not to enter graduate training at any school were: opportunity for a new position or a promotion; military service; change in financial circumstances, and "chose a different field for a career and thus a different course of study."

"This (last) factor may offer some ground for improvement through a combined program of counseling by all the programs in hospital administration," the report stated, adding that "better knowledge of the field and its opportunities for service might salvage some of this group for the hospital administration field."



Pour-o-vac

Sterile Fluid Flasking System



Eliminates the hazards of obsolete water sterilizers or makeshift fluids flasking methods . . . provides safe isotonic solutions in easy-to-handle containers . . . vacuum sealed to maintain sterility indefinitely . . . permits precise fluid temperature control . . . cost per use of less than two cents . . . the accepted technique in thousands of America's hospitals.

MACBICK

WRITE for literature and latest cost-reduction data on this modern POUR-O-VAC System.

THE MacBick COMPANY

Formerly Macalaster Bicknell Parenteral Corporation

For additional information, use postcard on page 279.

Responsibilities of Hospital Infection Committee Outlined by Joint Commission

CHICAGO. — Every hospital should have its own infection committee charged with responsibility for preventing, investigating and controlling inhospital infections, the Joint Commission on Accreditation of Hospitals recommended in a bulletin released here last month.

Membership on the committee should include representatives of the medical staff, administration and nursing service, the commission stated.

"Where possible, participation with community health organizations such as health departments, medical societies, and hospital councils is recommended, because the problem is not necessarily confined to the hospital itself," the bulletin added.

Responsibilities of the hospital infection committee include establishment of technics for discovering infection among patients and personnel, and among patients who have left the hospital, by sampling methods, the commission said.

Other committee responsibilities include:

1. Establishment of definite control methods.

2. Availability of bacteriologic services, either in the hospital or from a readily accessible outside source.

3. Systematic reporting of all infections among patients and personnel, and records which will provide a basis for studying the source of infection.

The committee should systematically review existing technics on all services, the commission recommended, with special attention to the following procedures involved in patient care:

1. Recheck all dietary and food handling procedures, such as proper dishwashing technics, preparation and disposal of food, refrigeration, sanitation of ice bins, and the disinfection of contaminated utensils and equipment. There should be a special technic for infected or "isolation" patients in the hospital.

2. Review laundry practices. This involves linen control, blanket control, special technic in handling and disposal of contaminated laundry in patients' rooms, nursery, operating room, and the laundry itself.

3. Study carefully methods of handling and disposing wastes and excreta of sputum, feces and urine, and the environmental wastes of dressings, floor sweepings, and food.

4. Restudy traffic controls and visiting rules in all areas, especially in operating rooms, nurseries and on obstetrical floors. They must be kept at an absolute minimum. Diligent maintenance of general cleanliness in all areas of the hospital, especially in service areas like utility rooms, janitors' closets, trash closets, and so on.

5. Check sources of air pollution. Air conditioning and ventilating units should be inspected regularly for contamination through intake sources, screens and filters (wet or dry). Hospital floors and corridors must be considered as potential spreaders of infection. Wet mopping is far preferable to dry sweeping. There should be a definite practice established for the care and cleanliness of the mop after each usage; a dirty mop spreads infection.

6. Routine, periodic culturing of autoclaves and water sterilizers, which is a must for all hospitals.

In addition, all personnel must be educated in the practice of proper

From HOLLISTER, the specialists in patient identification, come

TWO IMPORTANT ANNOUNCEMENTS:

1. New Low Prices for the *Ident-A-Band*®

Widespread recognition of the need for on-patient, all-patient identification, stimulated by the American Hospital Association's recent recommendation, has brought an unprecedented demand for Ident-A-Band, the *sealed-on* patient identification system. As a result of greater production, we are able to take advantage of the economies of volume manufacturing methods. We are passing these savings along to our customers in the form of *lower prices.*

2. A New Finger-Seal *Ident-A-Band*®

Along with its original Secure-Seal Ident-A-Band, Hollister now has a new Ident-A-Band with a *finger-pressure seal.* This seal, too, is *positive.* It cannot be unfastened or removed without destroying the band. It takes but a squeeze of the finger to seal. And the band itself is of the same comfortable, strong, skin-soft material that made the original Ident-A-Band so popular with millions of hospital patients.

The new Finger-Seal Ident-A-Band comes in two models — pre-fitted and custom-fitted. Perhaps you saw them at the Hollister booth during the recent American Hospital Association convention.

This new band enables Hollister to offer you an Ident-A-Band for every purpose and for every location in the hospital. Let us know and we will send you samples and further information, or will have our representative call on you.

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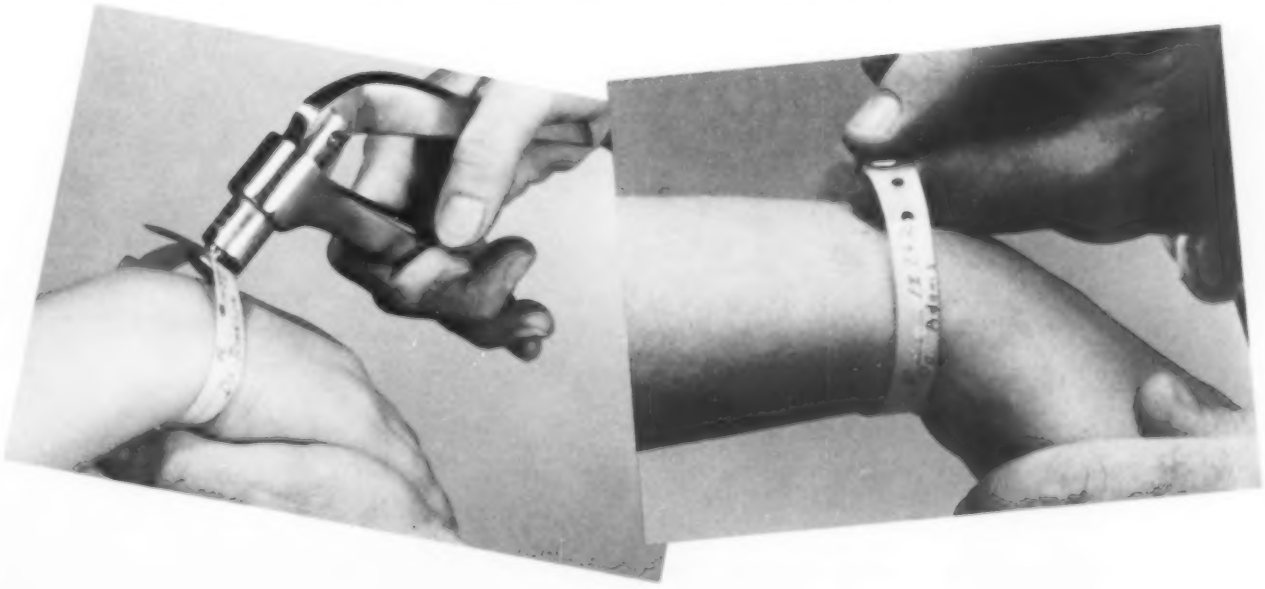


From HOLLISTER, the specialists in patient identification:

TWO NEW IDENTIFICATION ITEMS . . .

for the safety of your patients . . . and your hospital too.

Blood-Tab

for correlating the right blood with the right patient to prevent transfusion errors.

Lab-Tab

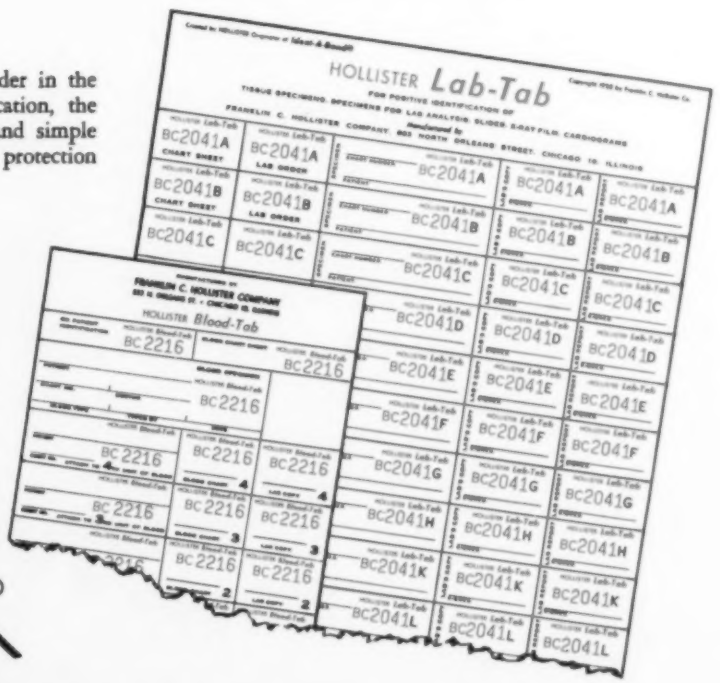
for correlating the patient with tissue and fluid specimens for laboratory analysis, slides, x-ray film and cardiograms.

Yes, the important word in identification of blood and lab specimens is *correlation.*

When a patient needs a transfusion, the Blood-Tab *correlates* that patient with the right container of blood from the Blood Bank.

When a specimen, a film or an EKG is required, the Lab-Tab *correlates* that specimen, film or cardiogram with the right patient.

Developed by Hollister . . . the recognized leader in the development of all-patient, on-patient identification, the Blood-Tab and the Lab-Tab represent a new and simple approach to the problem of assuring positive protection to your hospital's patients.



Write for Lab-Tab and Blood-Tab samples and complete information

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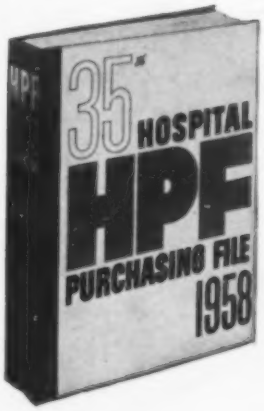

Always turn to HOSPITAL PURCHASING FILE when you choose any equipment or supplies—either familiar items or those you buy only occasionally—for detailed information to help you compare and select. Here, all in one place, are the catalogs of manufacturers who are most eager to help you make wise buying decisions. Catalogs are grouped by hospital departments and simply, accurately indexed to help you find what you are interested in easily and quickly. Keep Hospital Purchasing File on your desk. Be sure your department heads use it to speed up product comparison. Below is a list of catalogs of the essential building equipment (Section E).

catalogs of suppliers most eager to serve you

e.g.: turn to section E-building equipment

for catalogs of these firms

ADC Drapery Track Corp.
Adams & Westlake Co.
Alco Co., A. S.
Armstrong Machine Works
Azrock Floor Products Division, Uvalde Rock Asphalt Co.
Babcock & Wilcox Co., Boiler Division
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Barnhart Co., A. W.
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Blumcraft of Pittsburgh
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Capital Cubicle Co., Inc.
Celotex Corp.
Chamberlin Company of America, Inc.
Cincinnati Sub-Zero Products
Congoleum-Nairn Inc., Gold Seal Floors & Walls
Corbin Wood Products Division, The American Hardware Corp.
Cordley & Hayes
Dahlberg, Inc.
Dictograph Products Inc.
Dor-O-Matic Division, Republic Industries, Inc.
Dunham-Bush, Inc.
Elgin Softener Corp.
Excel Metal Cabinet Co., Inc.
Exide Industrial Division, The Electric Storage Battery Co.
Federal Flooring Corporation
Glynn-Johnson Corp.
Graybar Electric Co., Inc.
Grinnell Co., Inc.
Grover Co.
Hardwood Products Corp.
Harrison Steel Cabinet Co., Hospital Division
Herrick Refrigerator Co., Commercial Refrigeration Division
Hospitab Equipment Co.
Ingersoll-Rand Co.
International Boiler Works Co.
Jamestown Metal Products, Inc.
Jewett Refrigerator Co., Inc.
Jiffy Join, Inc.
Johnson Service Co.
Koch Refrigerators, Inc.
Lyon Metal Products, Inc.
Magic Door Sales, Stanley Hardware, Division of The Stanley Works
Marsh Wall Products, Inc.
Maysteel Products, Inc.
Medart Products, Inc., Fred
Morse Boulger Destructor Co.
Natco Corp.
Nelson Co., Inc., A. R., Hospital Division
Norton Door Closer Company, Division of The Yale & Towne Mfg. Co.
Onan & Sons Inc., D. W.
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Powers Regulator Co.
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St. Charles Mfg. Co., Hospital Division
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Stanley Works, The Magic Door Division
Stromberg-Carlson Co., Special Products Division
T. & S. Brass & Bronze Works, Inc.
Titusville Iron Works Co., Division of Struthers Wells Corp.
Trane Company
United States Motors Corp.
Uvalde Rock Asphalt Co.
Valley Metal Products Co.
Victory Metal Mfg. Corp.
Vinyl Plastics, Inc.
Watson Mfg. Co., Inc.
Western Industries, Inc., Electric Parking Gate Division
Western Railroad Supply Co.
Wilkinson Chutes, Inc.
Williams Pivot Sash Co.
Winpower Mfg. Co.
Yale & Towne Mfg. Co., The, Yale Lock & Hardware Division

For additional information, use postcard on page 279.

technics, the commission bulletin stated.

"An informed worker is a better and safer worker," the bulletin said. "It is especially important that physicians not consider themselves the exception to the rule, but both teach and set a good example for all. There can be only one accepted standard of practice."

Surveys by the commission indicate that the infection rate in hospitals using antibiotics routinely is higher than in hospitals not making such indiscriminate use of antibiotics, the bulletin reported.

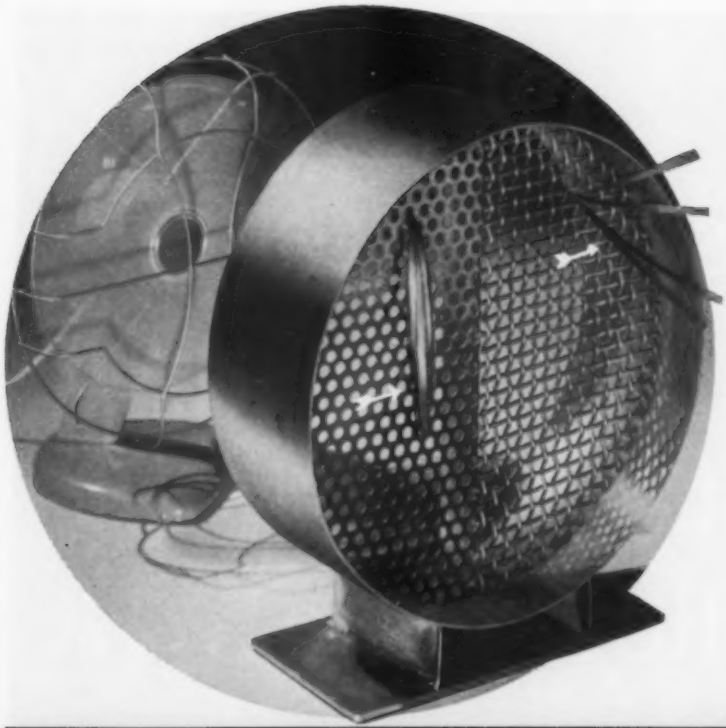
"The common denominator in hospital infections appears to be the resistance of bacteria to antibiotics used on the individual case. From this, the conclusions drawn are that this increase in infections is due to the routine, indiscriminate use of preventive antibiotics in the absence of infection, and the indiscriminate use of antibiotics in the presence of infection without preceding cultures and sensitivity tests. In this latter type of case it is more than useless, since with an adequate antibiotic one may only inhibit the infectious agent and also at the same time stimulate the growth of other organisms which then become pathogenic.

"There is no single factor responsible for so-called hospital infections," the bulletin concluded. "There are many factors and causes and each should be investigated."

N.L.N. To Continue Series Of Faculty Conferences

NEW YORK. — The National League for Nursing has received a grant of $61,886 from The National Foundation to continue a nationwide series of conferences for faculty members of schools of nursing, it was announced last month. Aim of the 18 conferences scheduled for 1958-59 is to stimulate better nursing care of patients in the future by improving teachers' abilities to plan curriculums and to instruct nursing students.

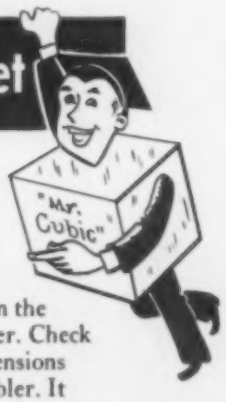
It was announced that the N.L.N. has planned a conference, to be held September 24-25 in New York, for presidents and executive secretaries of state leagues for nursing. Ways of promoting and financing state and local programs for improvement of nursing service and education will be among topics discussed.

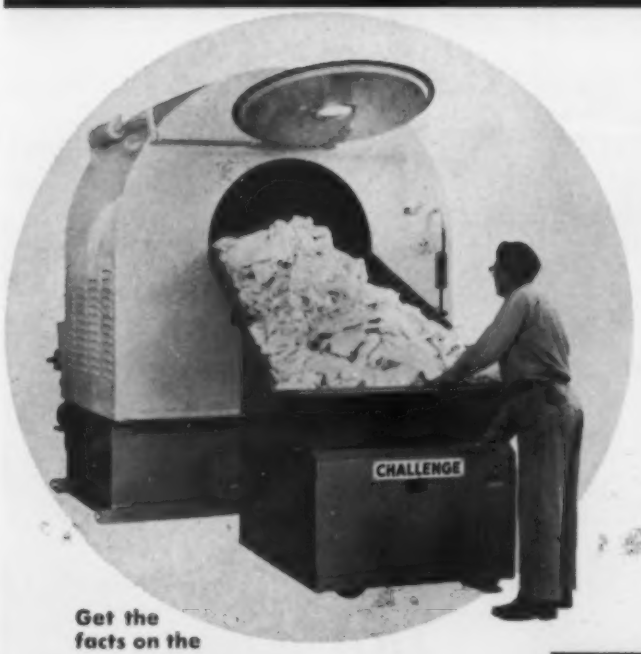


It figures . . . greater flow of air through the laundry tumbler results in faster, more efficient drying and conditioning. The new Drynamic Challenge Tumbler receives 50% more air through the sturdy woven wire basket than perforated sheet basket material used by most other machines. The Comparison test, photographed at left, shows how the unrestricted flow of air on the "Drynamic" side (woven wire) lets the *test ribbons* fly in the breeze, while the ribbons in front of the perforated sheet barely flutter.

Proven *on the job* too. At 60% retention, a 200 lb. (dry wt.) load of bath towels will fully dry in just 16 minutes . . . on other fabrics the Drynamic removes a gallon of water per minute.

Compare The "Air Flow" Through The Tumbler Basket





COMPARE THE CUBIC VOLUME TOO

Compare the cubic volume of the tumbler basket . . . it makes a tremendous difference in the efficiency of your tumbler. Check the tumbler basket dimensions before YOU buy a tumbler. It takes one cubic foot of basket area for every 2 pounds of material. The Drynamic has 95 cu. ft. of basket area. Competitive machines have only 69 or 72 ft., yet "rate themselves" at 200 lb. capacity.

Remember, the smaller the "cubics" (cubic feet of basket area), the longer the drying time. Compare the Drynamic's 95 cu. ft. basket with other machines claiming a 200# dry weight capacity.

Get the facts on the

Drynamic
CHALLENGE TUMBLER
IT'S THE FASTEST

✓ CHALLENGE MANUFACTURING CO.
7400 E. BANDINI BLVD • LOS ANGELES 22 • RAymond 3-1301

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New York Blue Cross Plans Urged To Cover Costs of Mental Care

NEW YORK. — State Blue Cross plans were urged last month to include hospitalization for mental illness in their basic contracts. Following a review of Blue Cross plans which do provide psychiatric coverage, State Superintendent of Insurance Julius S. Wikler said that such benefits would be "successful" and "not unduly costly."

The chairman of a mental health group also proposed that medical insurance coverage be expanded to include mental health. Anthony B. Akers asked Mayor Robert Wagner of New York to call a citywide conference to discuss mental health coverage, particularly in Blue Cross contracts.

He noted that state employes now are covered for mental health hospitalization, and urged the mayor to recommend that the contract for city employes also include mental health coverage.

The Blue Cross Plan of Rochester, N.Y., revised its basic contract on May 1 to provide up to 30 days of hospitalization for mental care, narcotic addiction, or alcoholism. Mr. Wikler said he would approve a similar provision in both old and newly issued contracts of other plans if they wished to provide the service.

Group Health Insurance of New York recently announced that it will furnish psychiatric services to a sample of its subscribers to determine whether costs will permit an equitable premium rate.

Charles Garside, president and chairman of Associated Hospital Service of New York, Inc., the New York City Blue Cross plan, said that Supt. Wikler's proposal will be studied by the plan's board of directors.

"We share the superintendent's concern about coverage of mental illness," Mr. Garside said, "but we know of no way in which it can be done unless subscribers are willing to pay the additional costs involved."

The present basic contract covers shock therapy and surgery for treatment of mental illness, Mr. Garside said. A rider is offered covering mental and nervous disorders, but only a very few groups are willing to pay the additional cost, he said.

At an insurance department hearing on Blue Cross rates, held June 3, Dr. Cornelia Wilbur of the National Association of Private Psychiatric Hospitals said coverage for mental and emotional illnesses could be provided by Blue Cross at about 4 per cent of the Blue Cross bill. Limited period coverage would cost proportionately less, it was noted.

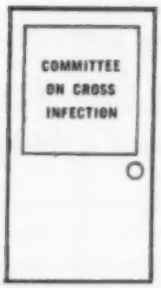
Maine Association Elects Littlefield

ROCKLAND, ME. — Dolnar H. Littlefield, administrator of Augusta General Hospital, Augusta, was chosen president-elect of the Maine Hospital Association at its 22d meeting held here recently.

Matthew I. Barron, administrator of Portland City Hospital, Portland, was installed as president, succeeding Lawrence M. MacDougall, administrator of Eastern Maine General Hospital, Bangor.

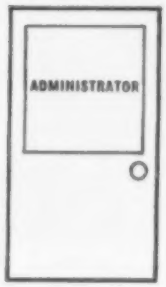
Other officers are: secretary, Sister Mary Mercy of Mercy Hospital, Portland, and treasurer, Willard C. Mosher of Webber Hospital, Biddeford. Merrill E. Tolman, administrator of Rumford Community Hospital, Rumford, was named delegate to the American Hospital Association.

Sufficient detergency to satisfy the Housekeeper, efficient disinfection to satisfy the Professional Staff, lighter labor costs to satisfy the Administrator, and minimum costs of best supplies to satisfy you – Tergisyl offers all.

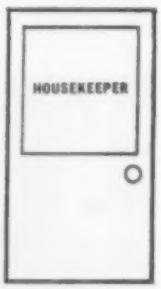


Better control of cross infection through simplified procedures is possible with the one-step Tergisyl method of disinfecting and cleaning. Reservoirs of staph, other common pathogens, and TB bacilli are destroyed routinely, efficiently with less effort.

For every 100,000 square feet of floor space in your hospital now cleaned and then disinfected by man-and-mop-and-pail, you can save as much as 5 man days per week, or 40 man hours, by adopting the one-step Tergisyl method.



Complete twice the work in half the time – and save money on both labor and materials. One-step Tergisyl cleaning procedure – which includes dependable disinfection – is quickly accepted, easier to follow.



Lehn & Fink's new weapon to combat cross infection

Best defense against spread of staph is careful attention to total environmental asepsis, including floors. With the Tergisyl method, efficient general disinfection is simultaneous with routine cleaning.

Tergisyl™

DETERGENT–DISINFECTANT

Cuts labor cost 47%

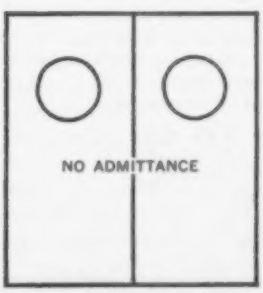
(by mop-and-pail method)

Cuts labor cost 22%

(by machine scrubbing-vacuum method)

Cuts material cost 5% to 10%

(using either of above cleaning-disinfecting methods)

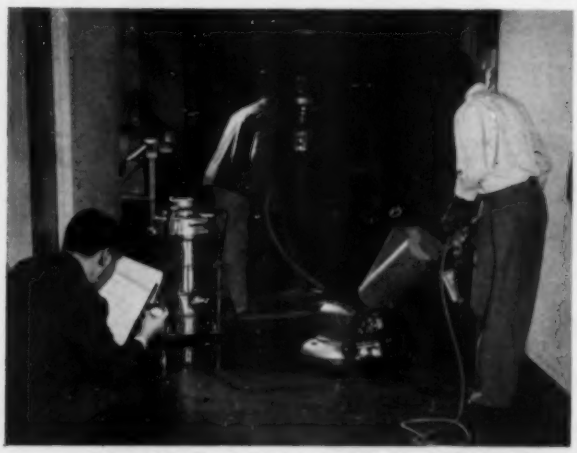


Keeping the O.R. "clean" in every sense of the word is easier, quicker with the new Tergisyl technic. Efficient disinfection and dependable detergency are combined in one cleaning step to achieve environmental asepsis you can be proud of. Has no effect on conductivity.

For details of comparative time studies under actual hospital conditions–

TURN PAGE

Comparative time studies of Tergisyl vs. conventional method washing and disinfecting using mop-and-pail technics. One-step Tergisyl method reduced the man-time required by 47%. Actual time saved was approximately 25 minutes per 1,000 square feet of floor area—a labor saving of 125 man hours or 15 man days per week in a 300-bed hospital.



Comparative time studies of Tergisyl vs. conventional machine scrubbing vacuum pickup, and mop-and-pail application of disinfectant. One-step Tergisyl method reduced the man-time required by 22%. Actual time saved was approximately 23 minutes per 1,000 square feet of floor area—a labor saving of 20 man hours or 2½ man days each week in areas of heavy soil in a 300-bed hospital.

Comparative cleaning and disinfecting efficiency of Tergisyl vs. conventional method. Subsequent inspection showed greater cleaning ability for Tergisyl than the detergent previously judged acceptable by the hospital. "Before" and "after" bacteriological tests confirm germicidal efficiency of Tergisyl.

Two-Thirds of Nurses Quit Jobs for Personal Reasons, Studies Find

NEW YORK. — Two-thirds of the resignations by hospital staff nurses are for personal reasons and are not related to their jobs or working conditions, a review of studies on the subject has revealed.

Writing in the current issue of *Nursing Outlook*, Lorraine K. Diamond and David J. Fox summarized five studies of nurse turnover that were conducted during the last 10 years. The authors currently are taking part in a study at the Institute of Research and Service in Nursing Education, Teachers College, Columbia University.

Home and family plans, leaving the city, and educational plans were cited by the nurses as personal reasons for leaving their jobs. Findings of the studies seem to indicate, the authors said, that two-thirds of resignations, therefore, probably cannot be avoided. This ratio is similar to that occurring among women workers in other occupations, they said.

Inadequate salary, inept supervision, lack of recognition, lack of responsibility, bad hours, unpleasant working surroundings, lack of social life, limited opportunity for advancement, and lack of fair appraisal were cited as specific reasons for job dissatisfaction among the hospital nurses.

One-third of the turnover might be avoided if aspects of job dissatisfaction could be identified and overcome, the authors pointed out.

New Hampshire Group Reelects All Officers

WHITEFIELD, N. H. — Norman R. Brown, administrator of Concord Hospital, Concord, was reelected president of the New Hampshire Hospital Association at its recent meeting.

Other officers, all reelected, are: vice president, Vernon Ballard, administrator of Portsmouth Hospital, Portsmouth; treasurer, Albert L. Beaulieu, administrator of Sceva Speare Memorial Hospital, Plymouth, and secretary, Thomas E. Edney, executive director of Blue Cross-Blue Shield in New Hampshire.

Named as trustees were: Chester L. Kingsbury, a trustee of Elliot Community Hospital, Keene, and William L. Wilson Jr., administrator of Mary Hitchcock Memorial Hospital, Hanover.

a plan of attack

against the spread of infections in hospitals

THE WAR IS ON! Never, since the days of Lister have hospital personnel been waging such a fierce war.

Then the enemy was all types of germs.

Today it is *Staphylococcus aureus* 52/42B/81 and other uncontrolled resistant strains. These organisms are producing serious infections in patients, newborn infants and hospital staff.

INFECTIVE AGENT AIR-BORNE. It has been rather clearly established that the infective agent is often air-borne in the form of dried fomites after originating in a septic wound. The primary means of distribution is the respiratory tract of hospital personnel. The pathogens settle everywhere. On floors, furniture, textiles, metal. Tests have shown them to be hardy—with survivals from a few days to many months.

These pathogens can spread from personal contact, from fomites on various articles, from droplets and dust.

There is only one apparent effective control: *complete disinfection throughout the hospital.*

It must be continual—there must be a return to the "old-fashioned" hospital attitude and methods of asepsis. The day is past when we can let antibiotics substitute for the tried and true methods of cleanliness and asepsis.

PLAN OF ATTACK AVAILABLE. Huntington Laboratories has developed a brochure which presents an outline for an overall control of infections in hospitals. To be successful, it must be instigated by the Administrative Head of the hospital. Copies of "A Suggested Plan for Infection Control in Hospitals" are available without charge. Send for it. We think you will find it helpful.

See your HUNTINGTON representative. At the right you will find a list of Huntington products that can help you fight infections in hospitals effectively. Nowhere, we believe, can you find such an imposing arsenal of products for fighting the broad spectrum of bacteria and for especially combating *Resistant Staph*, as at Huntington Laboratories.

The Man Behind the Drum . . . your Huntington representative, will gladly give you all of his time you need to answer your questions and to explain the Huntington plan. His experience can be extremely helpful to you.

These are some of the Huntington Products which have proved effective against infections including those caused by Resistant Staph

SAN PHENO X Non-specific Germicide
An all-purpose non-specific germicide that can be used on any surface unharmed by water. It has been thoroughly tested and is extremely effective against *Resistant Staph*. The key to controlling bacteria on all inanimate objects and equipment. Also important for personal hygienic use.

GERMA-MEDICA Liquid Surgical Soap with Hexachlorophene
For all surgical, obstetrical and related scrub-ups. For all staff and patient use, for handwashing to control skin bacteria. Now contains preservative to give Germa-Medica an even wider range of activity against Gram positive and Gram negative microorganisms. The key to controlling transfer of bacteria from hand to wound or mouth.

HEXA-GERM Antiseptic Skin Detergent with 3% Hexachlorophene
A cream lotion detergent with skin emollients. Reduces skin bacteria to safe levels immediately after first use. Used as an alternate for Hexachlorophene Germa-Medica in surgical scrub up. A proven product in fighting contagion in nurseries.

BABY-SAN Infant Soap with Hexachlorophene
The standard of highest quality among nursery soaps. Removes vernix, prevents infection, non-irritating. Controls pyogenic skin diseases. Baby San belongs in any wise program for improved aseptic conditions among patients.

KOREX All-purpose Germicidal Cleaner
Cleans, deodorizes and disinfects all at the same time. Korex has a phenol co-efficient of 3. It kills communicable disease microorganisms with a large margin of safety. Korex, San Pheno X, and San Pheno V (another all-purpose germicide) are highly effective against *Resistant Staph*. Important products in every pail of cleaning solution.

HUNTOLENE Antiseptic Dust Treatment
A floor dust treatment that inhibits growth of bacteria on floors as well as in the mop itself. Keeps dust down and germs out of the air. Controls the important air-borne organisms.

ODOR BAR Sanitizing Blockettes
Destroys odors chemically in urinals. Moisture releases an anti-bacterial vapor that deodorizes and sanitizes. Tests show a 94.4% bacterial reduction. Registered by USDA as a sanitizing agent.

ACCENT Hand Creme with Hexachlorophene
Contains hexachlorophene which produces bacteriostatic effect when used regularly. Made of fine, soothing creams. Excellent for chafed skin and used to prevent and control dermatitis.

HI-SINE Concentrated Iodine Detergent Germicide
A new germicide of the iodine type with a built-in signal to show Hi-Sine's effectiveness (and when the solution must be refreshed). Non-toxic, non-staining, non-irritating and multi-purpose. A product that is hard to misuse . . . sure to sanitize effectively.

H-Q GERMICIDE in Liquid or Tablet Form
Liquid quaternary ammonium. Disinfects linens, diapers, towels and clothes in the laundry. Has bacteriostatic residual action in the fabric. Available in tablets or liquid. Also excellent for use in sanitizing dinnerware, glasses and utensils.

FORMA-SAN Instrument Germicide with Hexachlorophene
Developed for sterilization and storage of instruments which will not stand heat sterilization. Tested and proved effective against many types of bacteria including five types of tubercle bacilli.

SANI-TATE Sanitizing Bowl Cleaner
A white emollient for cleaning, deodorizing and sterilizing toilet bowls and urinals. Removes dirt, rust or oil stains from porcelain without scratching. Helps control a potent breeding place for organisms.

TEST RESULT DATA FOR YOUR FILE

Check below the information you want

HUNTINGTON LABORATORIES, INC.

HUNTINGTON, INDIANA

Please send me information on the bacteriological test reports I have checked below and information on the products I have listed.

BACTERIOLOGICAL TEST RESULTS

- ☐ Research Bulletin: San Pheno X Germicide Kills Resistant Staph.
- ☐ Research Bulletin: Hexa-Germ Prevents *Staphylococcal* Skin Infection in the Newborn Nursery.
- ☐ Research Bulletin: Tests on the Preservative in Germa-Medica Liquid Surgical Soap. Also Irritation Test Results.
- ☐ Tests on Hexa-Germ Antiseptic Skin Detergent with 3% Hexachlorophene for Pre-Operative Surgical Hand Washing.
- ☐ Tests on the Bactericidal effect of Hi-Sine Iodine Detergent-Germicide.
- ☐ Brochure of Bacteriological Studies on San Pheno X Germicide.
- ☐ Test Results on Forma-San Instrument Germicide with *M. Tuberculosis*.
- ☐ Research Bulletin: "How to Control Contagion by Use of Germicides in the Hospital Laundry."
- ☐ Research Bulletin: "How to Use San Pheno V and/or Hi-Sine Germicides in the Hospital Asepsis Program."
- ☐ Brochure: "A Suggested Plan for Infection Control in the Hospital."

PRODUCT INFORMATION

Information on any of the products mentioned in the listing at the top of this page will be sent on request. Please indicate what you want by product name:

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NAME _____

TITLE _____

HOSPITAL _____

ADDRESS _____

CITY _____ STATE _____

For additional information, use postcard on page 279.

Voluntary Hospitals Report Costs Rise $1.82 Per Patient Day in 1957

CHICAGO. — Costs per patient day in voluntary hospitals increased $1.82 to $26.81 last year. Payment by and for patients was $1.52 per day less than their care cost hospitals, it was reported last month in the annual Guide issue of *Hospitals*.

Total income from all patients in all voluntary hospitals in 1957 was $2,878,254,000, while expenses were $3,050,398,000, the study of 6818 hospitals showed. Patient income made up 94.3 per cent of the total income of these hospitals, as compared with 96.1 per cent in 1956.

Average expenditure per patient in voluntary hospitals was $198.39, compared with $181.43 in 1956. The average patient stay was 7.4 days in 1957, a slight decrease from 7.5 days in 1956.

Hospitals cared for more patients than ever in 1957, and correspondingly provided more personnel per patient, the *Guide* revealed.

A total of 22,993,000 people were hospitalized last year, an increase of more than 900,000 over the 1956 total of 22,089,000. The number of babies born rose 248,118 in 1957 to 3,739,259, as compared with 3,491,141 in 1956.

An average of 107 employes per 100 patients were employed in all hospitals in 1957; in 1956, there were 101 staff members per 100 patients. Voluntary short-term hospitals employed 218 persons per 100 patients; nonfederal psychiatric hospitals had 32 staff members for 100 patients.

The 6381 nonfederal hospitals reported expenses of $5,483,096,000, of which 62 per cent, or $3,402,172,000, went for payroll. These hospitals employed 1,215,388 of the 1,401,232 persons in all hospitals.

More than half of the hospitals in the United States last year were voluntary, 16 per cent were proprietary, and 32 per cent were operated by agencies of federal, state or local government, the report said.

Ninety-five per cent of all admissions were to general hospitals, but psychiatric hospitals cared for 51 per cent of the total number of patients hospitalized on any one day.

Thirty-six per cent of all hospitals in this country had less than 50 beds, 23 per cent had from 50 to 99 beds, 27 per cent had between 100 and 299 beds, and 14 per cent had 300 beds or more, it was reported.

Other statistics in the report included expenditures in psychiatric hospitals, which averaged $9.73 per patient day in federal institutions, $14.88 in voluntary hospitals, $14.70 in proprietary hospitals, and $3.66 in state and local governmental hospitals of this type.

Psychiatric and general hospitals each had 45.5 per cent of the total of 1,558,691 hospital beds in the continental United States, with the remainder equally divided between tuberculosis hospitals and other special institutions.

Home Joins University

CHICAGO. — The Chicago Home for Incurables has become affiliated with the University of Chicago, under an arrangement by which the home will construct a new hospital near the university clinics and become a model center for study and treatment of chronic illness, particularly in geriatric patients, it was announced last month.

Johnson Pneumatic Controls Can Help Make Your Hospital More Efficient

The ability to automatically match room temperatures and humidities to each of many specialized demands can make important contributions to any hospital's efficiency.

An optimum thermal environment may safeguard a patient's life. It helps shorten recovery periods, protects vital research processes, saves valuable staff time and reduces heating and cooling costs substantially!

A Johnson Pneumatic Temperature Control System with *individual room* control can bring these benefits to your hospital. Only a pneumatic control system can meet the diversified temperature and humidity requirements of the modern hospital and do it so simply, safely and economically.

Pneumatic control is far easier, less costly to operate, offers complete flexibility to meet every need. It's safe under all conditions—*even in the presence of explosive gases.* Upkeep is less—pneumatic control components outlast all other types. And only pneumatic controls can be used effectively with all types of heating and cooling systems.

Let Johnson help improve the efficiency of your hospital by installing a control system that will assure you of an ideal thermal environment. A nearby Johnson engineer will welcome the opportunity to discuss with you, your consulting engineer or architect the control system best suited to your particular needs. Johnson Service Company, Milwaukee 1, Wisconsin. Direct Branch Offices in Principal Cities.

JOHNSON CONTROL

PNEUMATIC SYSTEMS

DESIGN • MANUFACTURE • INSTALLATION • SINCE 1885

For additional information, use postcard on page 279.

Careers Group To Hear Proposed National Study Of Laboratory Workers

CHICAGO. — A nationwide study of medical laboratory work, including problems of supply, function, training and utilization of personnel was outlined here last month by Dr. Frank B. Queen, chairman of the Medical Laboratory Planning Conference held in September 1957.

The comprehensive study, to be presented to the National Committee for Careers in Medical Technology at its November meeting, will gather the following information: ratio of the number of types of medical laboratory personnel to the number of patients and the number of physicians; extent of shortages in medical laboratory workers; most efficient utilization of personnel; optimal education requirements; remuneration; conditions of employment, and recruitment.

Delegated by the American Society of Clinical Pathologists to find facts about medical technology that would help the society plan future goals, Dr. Queen discovered few available data. As a result, the planning conference was held, attended by representatives of the society, Boards of Registry and Schools of Medical Technology, American Society of Medical Technologists, American Hospital Association, and American Medical Association. The proposed study was developed following the conference.

North Carolina Hospitals Elect Slate of Officers

BLOWING ROCK, N.C. — Edward R. Frye, administrator of Good Samaritan Hospital, Charlotte, was named president-elect of the North Carolina Hospital Association at its annual meeting.

Sample B. Forbus, director of Watts Hospital, Durham, was installed as president.

J. Minetree Pyne, administrator of Alamance County Hospital, Burlington, was named to succeed Mr. Forbus as secretary-treasurer. Trustees are: W. W. Lowrance, Memorial Mission Hospital, Asheville; George W. Laycock, Cleveland County Hospital, Shelby, and Lloyd Gilbert, Johnston Memorial Hospital, Smithfield. R. Z. Thomas Jr., Charlotte Memorial Hospital, Charlotte, was named delegate to the A.H.A., and J. P. Richardson, Presbyterian Hospital, Charlotte, was named alternate.

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Citizens Committee Joins Fight To Close Milwaukee County Emergency Unit

MILWAUKEE. — A special citizens committee recommended last month that the emergency unit of the Milwaukee County Hospital be closed because "it does not meet the standards required for the best total care of the emergency patient."

The committee, formed last April to study the hospital, following year-long controversy over its services, criticized the shortage of doctors and other trained personnel and lack of modern equipment and facilities. In July, John W. Rankin, director of county institutions, also had warned that a lack of doctors might force the hospital to close.

The committee's report, which was to be presented to the county board of supervisors September 8, urged the board to consider contracting with private hospitals to provide emergency care and repaying them when necessary.

The county board of public welfare voted last year to close the hospital and move its emergency-dispensary facilities to a new wing of the county general hospital in Wauwautosa, a Milwaukee suburb, but the county board of supervisors overrode sections of the welfare board's decision. The dispensary unit has been transferred, but the emergency unit remains in Milwaukee. Mr. Rankin also commented last month on the increased expense involved in running the hospitals separately.

City police and fire departments and the sheriff's office have opposed closing of the emergency unit and transfer to the suburban location, saying that the extra distance to the suburb could cost an emergency patient his life.

The Milwaukee Hospital Council has said that private hospitals would not consider establishing emergency facilities until the board decided to close the emergency hospital. If this happened, private institutions would study whether emergency facilities were needed, the council said.

Officers Named To Head Tri-State Assembly

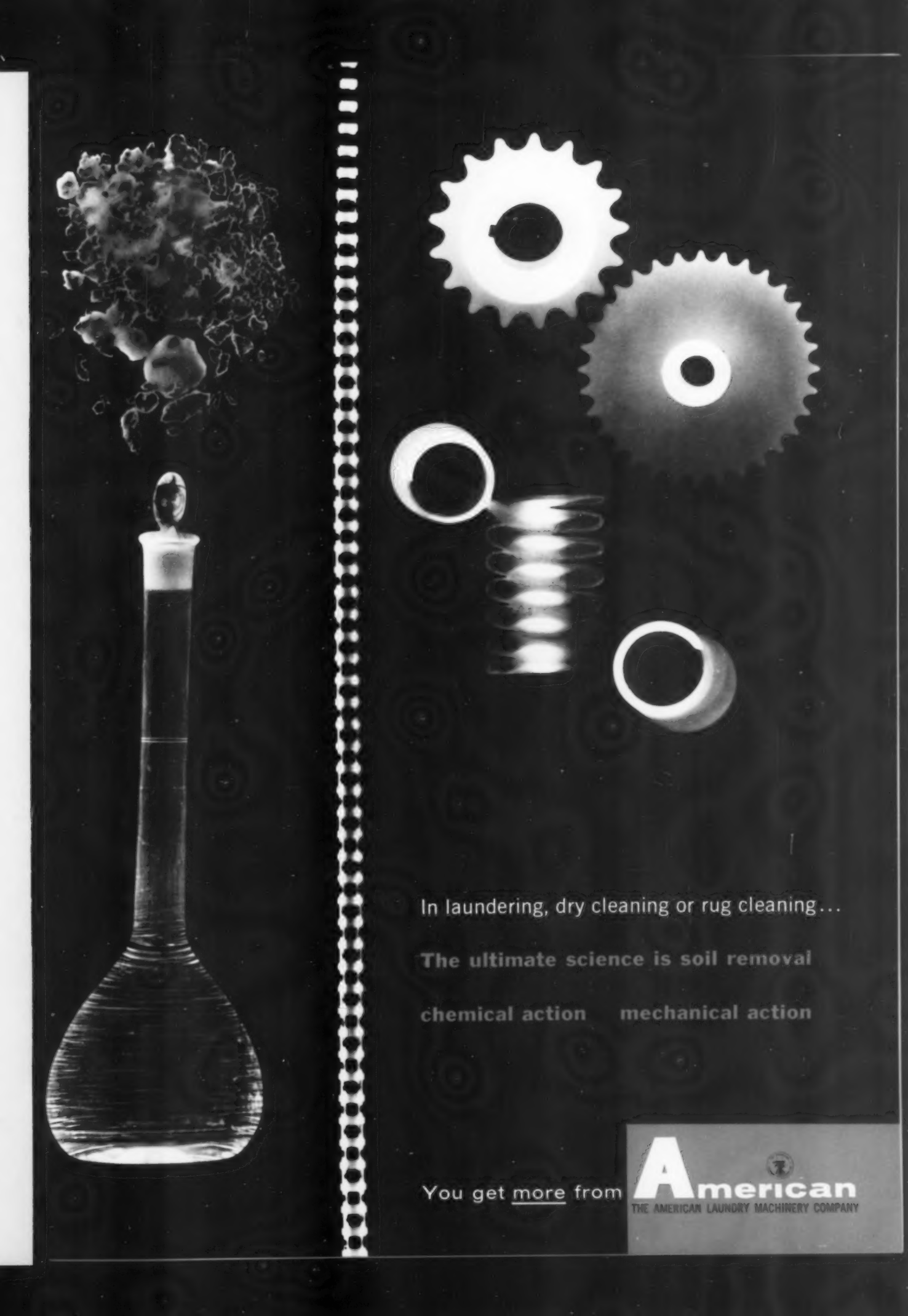
CHICAGO. — John W. Rankin, director of Milwaukee County Institutions, Milwaukee, was named president of the Tri-State Hospital Assembly at a recent meeting of the directors.

Other officers are: vice president, George E. Cartmill Jr., director of Harper Hospital, Detroit; recording secretary, Sister Mary Reginald, R.S.M., of Mercy Community Hospital, Manistee, Mich., and treasurer, Delbert L. Price, administrator of Children's Memorial Hospital, Chicago. Albert G. Hahn remains as executive director, and Leo M. Lyons continues as program director.

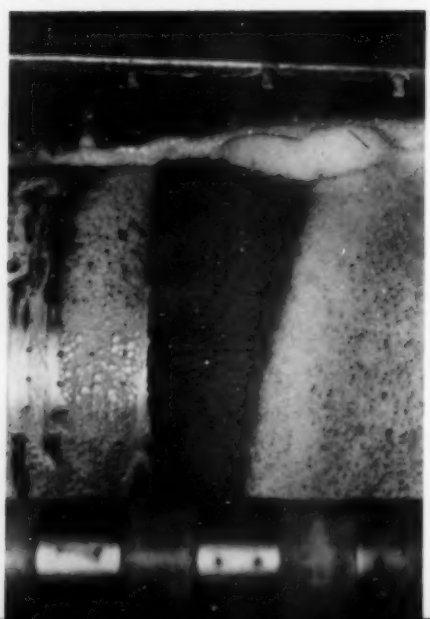
Elected to the board of directors for three-year terms are: Ralph M. Haas, administrator of Culver Union Hospital, Crawfordsville, Ind.; A. Kent Schafer, administrator of James Decker Munson Hospital, Traverse City, Mich., Mr. Rankin, and Mr. Price.

Foundation Changes Name

NEW YORK. — The National Foundation for Infantile Paralysis has changed its name to The National Foundation, it was announced recently. Plans of the organization include research and an eventual patient aid program in arthritis and congenital malformations. Virus research will be continued and expanded, as will current investigations into disorders of the central nervous system, officials said.


In laundering, dry cleaning or rug cleaning...
The ultimate science is soil removal
chemical action mechanical action
You get more from American
THE AMERICAN LAUNDRY MACHINERY COMPANY

Chemical action, mechanical action— the scientific basis of laundry, dry cleaning and rug cleaning machinery design



Ultimately, the reason for laundering, dry cleaning or rug cleaning is to remove soil from fabrics, then finish them properly. All successful methods involve both chemical and mechanical action. The most efficient use of these principles is the basic consideration in machinery design.

Here at American, our research and development people are continually testing chemical properties, new principles of mechanical agitation, the effects of heat and pressure—to the end that we are confident all of our products make full use of the latest scientific knowledge available.

The fact that we design and build laundry, dry cleaning and rug cleaning machinery is a distinct *advantage*. Often a dry cleaning discovery leads to a laundry improvement, or a laundry development is applicable to rug cleaning, and vice versa. Soil removal is the common thread.

Our Research Program is the only one of its kind, because only American serves every segment of the entire textile cleaning industry—commercial, industrial, linen supply, institution, quick-service and coin-operated laundries; dry cleaning; rug cleaning.

Our experience, devoted to all phases of the textile cleaning industry, and *only to this industry*, is still another way you get more from American.

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dictate it letter-perfect with a Voicewriter

The operation's over . . . a report begins. It must be accurate to the letter . . . and it will. For the surgeon has but to pick up a nearby phone . . . one of the dictating stations in the hospital's Edison Voicewriter system . . . and make the postoperative report while every detail is fresh in mind. Then a medical secretary just transcribes from the Voicewriter Diamond Disc without the possibility of error as with shorthand dictation.

Records are better—staffs are happier! No waiting for a secretary to take dictation . . . no valuable time spent writing longhand reports. Your doctors complete postoperative reports, consultation notes . . . any medical record you require, with half the effort. Even the busiest staff can keep records up-to-date, complete and accurate.

Secretaries eliminate backlogs! No problems deciphering doctors' written reports. No hours consumed taking shorthand dictation. When they transcribe from the Voicewriter Diamond Disc, the doctor's voice comes through clearly, even easier to understand than in direct conversation.

Here's where to put Voicewriter on duty! Have this dependable "secretary" on duty for dictation wherever records originate: in the surgical suite, doctors' offices, nurses' stations, clinic rooms, pathology and radiology. You'll get the complete, accurate medical records a good hospital must have . . . and they'll be up-to-date.

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For additional information, use postcard on page 279.

Half of Operations Done By Certified or A.C.A. Surgeons, Survey Shows

(*Continued From Page 76*)

nonsurgical specialty, and one by a physician who was not certified but reported his practice was limited to a nonsurgical specialty.

An analysis of the procedures by type of hospital indicated that the proportion of operations performed by specialists increases as hospital size increases. In hospitals of less than 50 beds, 19 per cent of the operations were performed by specialists; in hospitals of 50 to 99 beds, 35 per cent of the operations were performed by specialists; in hospitals of 100 to 249 beds, 59 per cent of the operations were performed by specialists; in hospitals of 250 to 499 beds, 60 per cent of the operations were performed by specialists, and in hospitals of 500 or more beds, 80 per cent of the operations were performed by specialists.

The survey also included an analysis of 224 obstetrical cases. Of this number, 17 per cent were attended by certified specialists, 21 per cent were attended by doctors whose practice was limited or special attention given to obstetrics or gynecology; 16 per cent were attended by doctors limiting their practice to another specialty, and 38 per cent were attended by general practitioners.

In the remaining 8 per cent of births, it was reported, there was no physician in attendance.

The authors emphasized that the report, because of the size of the sample, was simply "exploratory."

"We have been able to present only the broad outline as a springboard for further research," they said. "Although the size of our sample does permit the general analyses presented here, a much larger sample would be necessary for detailed analysis of different types of surgery, the age, experience, and training of the surgeons, age of patients, and many other relevant matters."

Western Pennsylvania Council Names McGibony

PITTSBURGH. — Dr. John R. McGibony, director of the University of Pittsburgh Graduate School of Public Health, has been named president of the Hospital Council of Western Pennsylvania.

Other officers are: vice president, Robert J. Dodds Jr.; treasurer, Sidney M. Bergman, executive director of Montefiore Hospital, Pittsburgh, and secretary, William A. Hacker, administrator of McKeesport Hospital, McKeesport. Members-at-large, elected for three-year terms, are Edward V. Graef and Elmer J. Tropman. Sister M. Adele, Leslie J. Reese, and John T. Ryan Jr., immediate past president, were elected to three-year terms on the executive committee.

V.A. Finds Family Forums Can Aid Mental Patients

WASHINGTON, D. C. — Meetings for families of mentally ill veterans have helped a considerable number of patients in Veterans Administration hospitals to return home and lead more normal lives, it was reported last month.

The meetings, held at the hospitals, give relatives an opportunity to learn more about psychiatric illness and treatment and to exchange ideas on coping with family problems, said Dr. John J. Blasko, chief of the psychiatry division in the V. A. psychiatry and neurology service.

SINCE 1860

Nurses Station Equipment to Do You Have in Mind

Aloe-Exclusive Units Developed To Do A Specific Job Alone Or Coordinated In Assemblies Of Any Desired Size.

Whether you plan a Nurses Station to provide nursing service for a small number of beds or a large, busy division, Aloe has designed and manufactures equipment for the job.

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Aloe recognizes complete acceptance of any Aloe developed unit only after long use in a large cross section of the nation's hospitals. Each unit shown here is now in use in many of the world's leading hospitals, and is fully accepted as equipment designed and built according to the highest standards in the industry.

Aloe-Designed and Manufactured

All the equipment shown here was originally designed and is manufactured in our own St. Louis factory. Experienced Aloe equipment engineers work closely with hospital authorities to develop specific units or coordinated assemblies to meet the exact requirements of the hospital user.

Functionally Interrelated Units

Aloe Nurses Station equipment has been designed to function in coordinated groups regardless of size of assembly. Time and labor is saved, permitting a greater volume of work to be accomplished in less space with minimum confusion.

Planning Service

Aloe Equipment Planning Service, staffed by experienced equipment specialists, is prepared to give you expert assistance in equipment lay-out and selection. Write or see your Aloe Representative for details.

You will find complete specifications of Aloe Nurses Station Equipment in our 804-page General Catalog No. 189. If this world's most complete catalog is not in your files, your Aloe Representative will be happy to supply you with a copy.

A. S. Aloe Company / *World's Foremost Hospital Supplier*

1831 Olive St., St. Louis 3, Mo. • *14 FULLY-STOCKED DIVISIONS COAST-TO-COAST*

Multi-Service Storage-Sink unit with Narcotics Locker—a complete work center.

McGregor Chart Desk—combines desk with 20, 30 or 40 chart storage capacity.

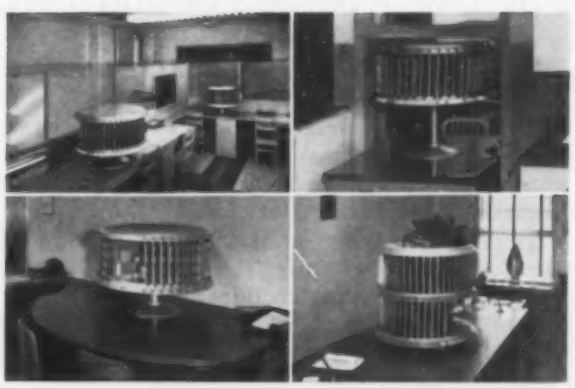
Midget McGregor—saves space in close quarters—18-chart capacity.

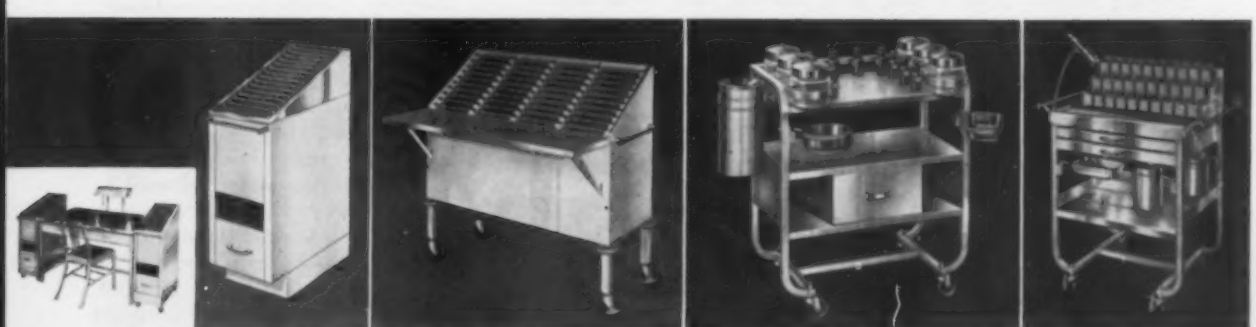
Suggested assembly of modular 15-chart units may be assembled in banks.

The Job

The Aloe-Exclusive Revolving Chart Holder (at right above) has gained tremendous popularity during the past decade. Reasons are obvious: unequalled convenience in actual use, and great variety of possible arrangements for convenience of access. Arrangement shown above (left) solves a common problem involving free access to the charts by both doctors and nurses without mutual interference. Counter model unit may be placed between areas divided by an actual partition or opposite seating. At right is shown a few of the many other possible arrangements of this versatile unit.

Available in 20, 30 and 40 chart capacities. Mobile unit also available (inset).





Mobile unit used alongside Nurses desk. Easy to modify or expand.

Mobile Chart File with folding work shelf; available 20, 30, or 40 chart capacity.

Alumiline Koenig Dressing Cart carries complete facilities for dressing service.

Alumiline Dispense-Cart—a complete, one-trip medicine dispensing unit.

For additional information, use postcard on page 279.

Student Gives Overdose Of Drug; Patient Death Is Ruled Accidental

CHICAGO. — Death of a patient due to wrong dosage of a medication was declared accidental by a coroner's jury following a public hearing here last month.

The patient died at St. Luke's Hospital July 20, it was reported, after a senior student nurse gave the wrong dosage of paraldehyde.

The nurse testified she had mistaken a doctor's prescription for three drams of the drug, interpreting the symbol for drams to means ounces.

The student reported she had measured the mistaken dosage from a floor stock of the drug.

Joseph Greer, administrator of the hospital, told the coroner's jury that the hospital's therapeutics committee was studying prescription-writing methods with a view to revising the system to prevent any possible misinterpretation. Since the accident, he added, paraldehyde and other drugs are being distributed to patients only from the hospital pharmacy.

Mr. Greer said the student nurse would continue with her training and graduate with her class. She was described as "a competent nurse" by the hospital's director of nursing service, who also testified.

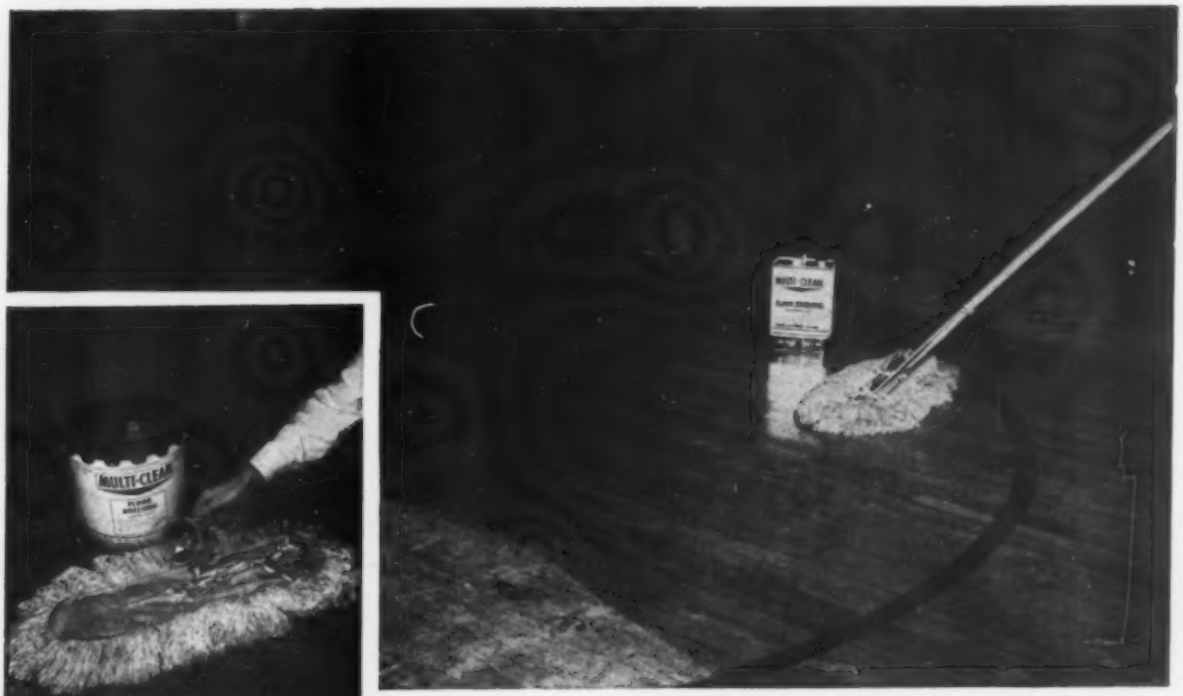
Connecticut Association Chooses New Officers

BERLIN, CONN. — Charles T. Treadway Jr., president of Bristol Hospital, Bristol, was named president-elect of the Connecticut Hospital Association at its 40th annual meeting recently.

Robert C. Kniffen, managing director of New Britain General Hospital, New Britain, was installed as president.

Other officers are: treasurer, William G. Boies of the Colonial Trust Company, Waterbury; trustee-at-large, Dr. T. Stewart Hamilton, executive director of Hartford Hospital, Hartford, and delegate to the A. H. A., Dr. I. S. Geetter, director of Mt. Sinai Hospital, Hartford.

Named as regional delegates to the board of trustees were: Sigmund L. Miller, Park City Hospital, Bridgeport; Rev. Peter J. Gerety, Hospital of St. Raphael, New Haven; David Keppel, McCook Memorial Hospital, Hartford, and William H. Sisson, Litchfield County Hospital of Winchester, Winsted.



HOW TO PREPARE MOP. Pour FLOOR DRESSING over top of mop at rate of 1 to 1½ ounces for each 4" of mop.

Next, roll up mop and store in plastic bag or other airtight container for at least 4 hours. This allows FLOOR DRESSING time to become evenly distributed throughout mop.

How to stop rubber marks

Do unsightly black rubber marks destroy the beauty of *your* floors?

Then you'll be delighted by the improvement when you begin using Multi-Clean FLOOR DRESSING.

A quick daily dust mopping with a mop treated with FLOOR DRESSING leaves a thin film that's highly resistant to marks by rubber or other materials.

But that's not all! Your wax or resin finish takes on new beauty. It has higher lustre, a harder surface. FLOOR DRESSING greatly improves anti-slip properties and extends wearing life of the wax.

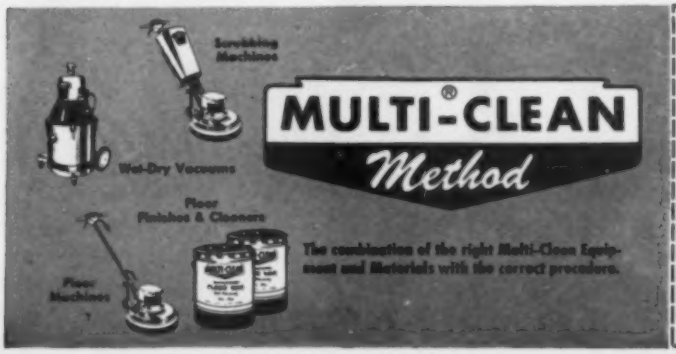
And it *cleans* at the same time as it polishes and preserves. Since the treated mop picks up and holds free dust, there's no need for sweeping compound. *You'll save hours of time and gallons of material.*

FLOOR DRESSING has a pleasant aroma, presents no fire hazard, and is listed by Underwriters' Laboratories as anti-slip. It also tends to discourage development of floor-dwelling bacteria and fungi.

For all floors. You can use Multi-Clean FLOOR DRESSING on all type floors, for it contains no ingredient that can harm any floor that's properly treated. It's available in 55, 30, 15, 5 and 1-gallon containers.

FLOOR DRESSING is just one of 27 modern cleaners, sealers, and finishes developed by Multi-Clean Research. For more information on this outstanding mop treatment and scientific MULTI-CLEAN METHOD for maintaining *your* floors, call your local Multi-Clean Distributor or mail coupon today. You'll be under no obligation.

ANOTHER PRODUCT OF MULTI-CLEAN RESEARCH



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☐ Concrete ☐ Rubber Tile ☐ Vinyl Tile
☐ Other (specify)_____

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City_____ Zone____ State_____

For additional information, use postcard on page 279.

Members Contributed 10,000 Hours To A.H.A. Activities, President Says

CHICAGO. — More than 400 members served without pay on various committees and councils of the American Hospital Association last year, Tol Terrell of San Angelo, Tex., association president, said in his annual report published here last month in advance of the A. H. A. convention.

These members contributed an estimated 10,000 hours of productive effort to association affairs, not including travel time, Mr. Terrell said.

The president's report was published in book form along with reports of other officers, committees, councils and special activities of the association.

The reports were to be presented to the House of Delegates at the annual meeting in Chicago, August 18.

The association lost 54 hospital memberships because of the 50 per cent temporary dues increase in 1957, the president reported — 29 from the United States, and 25 from Canada, the report stated.

"This loss, regrettable despite its smallness, was less than the gain in membership during the same period," Mr. Terrell reported. "During the same period 50 hospital memberships, new or reinstated, were recorded and the steady growth of Type V (auxiliary) membership continued. Our personal membership also grew and actually over the six-month period (ending March 31, 1958) there has been a net growth in association income from membership."

Reporting on progress with the new association headquarters building on Lake Shore Drive, Mr. Terrell said:

1. Exterior walls were "nearly complete," with brickwork finished to the top floor and aluminum window walls to the 11th floor.

2. All concrete floors were poured and most of the plaster partitions were constructed.

3. Acoustical tiling was 50 per cent complete; ceramic and quarry tiling was in place, and 50 per cent of other stonework completed.

4. Seventy per cent of the work of the mechanical trades was completed.

John N. Hatfield, treasurer, said the institutional resignations resulted in a loss of regular dues of $12,674 and temporary dues of $4941.

"Even this loss has not reduced total regular dues below the 1956 level," he added, "primarily because of the new members and because of increased occupancy levels for the year on which the dues for 1958 were computed."

Noting that a budgeted addition of $120,000 to contingency funds for 1957 had fallen short by $69,000, Mr. Hatfield explained:

"The year 1957 saw a number of new publications distributed to the membership. Among these were 'Cost Finding for Hospitals,' 'Accreditation References,' the newly revised 'Physical Therapy Manual,' a revision of the 'Model Constitution and By-laws for a Voluntary Hospital,' to name just a few.

"In addition the association began two new monthly services to the members, the 'Public Relations Newsletter' and 'This Month in Washington.' Both of these fill a need in the field.

"Another item worthy of consideration is staff travel. I'm sure you all realize the tremendous job of representation which the staff is called upon to do for the membership. I use the word tremendous to describe the quantity as well as the quality of the work. Other items which cost more than had been anticipated are statistical services, telephone and telegraph, personnel recruitment, and professional fees."

University of Washington To Reduce Study Hours In Nurse Training Course

(*Continued From Page* 160)

"Our studies have emphasized that it is the quality, not the length, of the nursing instruction that leads to best preparation of nurses," said Dean Tschudin.

"We feel confident that this new program will turn out nurses who are well prepared for their responsibilities. It's a question of using the student's time more efficiently."

The university's experimental three-year program, conducted at one hospital, was intended to give an answer to whether nurses could be adequately trained for registration in that time. Under its terms, students could write their examinations after three years or study for another year and obtain their bachelor degrees. A high percentage elected to obtain their degree.

In addition to providing a speeded-up nurse training plan, the experimental program was used for continuous research on curriculum, methods and emphasis. As announced in 1952, it reduced the term of study by eight months, permitted students to be examined for registration after nine months on campus and 28 at Virginia Mason Hospital, and still get full credit for this period toward their degree.

Continuous comparisons with students in other divisions of the school were made. One of the biggest reductions under the experimental plan called for reduction of practice of operating room procedure from 11 weeks to four weeks plus 14 hours of instruction and observation.

Another goal was to see whether students could absorb theory better by putting it into practice at the same time they were exposed to it, or by learning theory at one time and getting the practice some time later.

Pope Asks Specialized Health Professions To Cooperate as Team

BRUSSELS. — The increasing complexity of health care and health organizations make effective collaboration among the many specialized health professions more needed than it has ever been before, Pope Pius XII said in an address broadcast to a World Catholic Conference on Health, meeting here last month.

He urged the conference to work toward devising practical means for better organization of the health team.

"You are not unaware of seeing the sick treated not as a person but as a case," he concluded. "Sometimes it happens that dangerous investigations are undertaken to complete the diagnosis, where they have no real usefulness; or sometimes a sick person is subjected to regretful consequences of administrative measures which are primarily aimed at assuring the convenience of the service."

At the same time, the Pope warned, increasing specialization has been accompanied by "a certain narrowness of judgment" which has made collaboration among the professions less effective than it should be.

In addition, the Pope told the conference, members of the professions are hampered by "the common weaknesses of humanity — sensitiveness, impatience, the desire to prevail, intolerance of discipline."

Doctors must cooperate not only with one another and with the nurses who assist them in caring for the sick, but also with administrators, secondary staffs, chaplains, families of the sick, social insurance organizations, and public authorities, the Pope declared.

Pharmacists Paid $402, Nurses, $269, Atlanta Salary Survey Reveals

ATLANTA. — Staff nurses in Atlanta hospitals average $269 in salary per month, a survey being conducted by the Georgia Hospital Association and the hospital services division of the state health department has found.

Pharmacists were the highest paid personnel studied, receiving $402 per month for a 42 hour week.

Preliminary statistics released last month showed staff nurses' salaries ranged from $229 to $310 per month in seven Atlanta hospitals. This group, which included floor duty nurses, head nurses, and nurse supervisors, other than nursing service directors, worked a 40 hour week, the study found.

Salaries of operating room nurses averaged somewhat higher, $283 per month for a 42 hour week. Practical nurses' salaries ranged from $171 to $208 per month, with an average of $188. Nurse's aides averaged $145 per month, and orderlies received $149.

X-ray technicians were paid $292 per month for a 42 hour week. Medical record librarians' salaries varied from $194 to $312, with $237 as the average.

A. D. A. dietitians were paid $335 on the average, with other food supervisors receiving $242, and general kitchen help, $124.

Housekeepers' salaries ranged from $234 to $330, with $252 as the average. Maids and janitors averaged $105 and $134 per month, respectively, for a 44 hour week. Laundry supervisors were paid an average of $233 per month, with laundry helpers receiving $118.

$1 Million Hospital For Dental Patients Started in California

LOS ANGELES. — Ground breaking ceremonies for Southern California Dental Hospital, said to be the first major hospital exclusively for dental patients, were held here July 30. The $1 million, 80 bed hospital is located in the Hollywood-Los Angeles Medical Center, near Kaiser Foundation, Children's, Hollywood Presbyterian, and Cedars of Lebanon hospitals.

The Los Angeles County Dental Society will establish credentials standards for dental staff admissions and has appointed a committee to approve applications.

High-speed turbine drills, high-velocity vacuum systems, and closed-circuit television will be utilized in the 16 operating rooms. A recovery room also is to be provided.

Architects' rendering of $1 million dental hospital planned for Los Angeles area. Hospital is reported to be the first for dental patients only.

The private rooms for patients will have enclosed patios, sliding glass doors, electronically controlled draperies and beds, and built-in television and radio systems with bedside controls.

Complete air conditioning and a two-way communication system are included in the plans.

Kegley, Westphall & Arbogast of Los Angeles are the architects.

Banquet Speaker Calls Collective Bargaining Essential for Hospitals

CHICAGO.—Collective bargaining with hospital employes was recommended as "essential to equity, fair play and effective two-way communication," at the 24th annual banquet of the American College of Hospital Administrators here last month.

Delivering the 10th annual Arthur C. Bachmeyer Memorial Address to a banquet audience of 650 College members and guests, Ordway Tead, vice president of Harper & Brothers, New York, said some kind of "negotiative dealing" that is not purely individual bargaining should be recognized by hospital administrators today.

"In large scale hospital operations," Mr. Tead said, "some equivalent of collective bargaining or organized employe representative spokesmanship with real powers is essential to equity, fair play and effective two-way communication.

"Only as there is the economic security, sufficiency and status of worker group by profession, craft or job, is it possible to call forth the attitude of mind, the motive of creativity, from which improvement of work quantity and quality can be appealed for with any likelihood of success."

Mr. Tead described the hospital administrator as "the chief facilitator, expediter and integrator of diversified but necessary functions and labors on the part of a variety of associated individuals and groups," in an address entitled "Reflections on the Art of Administration."

At the annual convocation ceremony preceding the banquet, the College conferred honorary fellowship on 25 men and women for their contributions to the health field. They were:

Ella Best, R.N., New York; retiring executive secretary, American Nurses' Association.

Galloway Calhoun, Tyler, Tex.; chairman, board of trustees, Shriners Hospitals for Crippled Children.

Nelson H. Cruikshank, Washington, D. C.; director, Department of Social Security, A.F.L.-C.I.O.

Robert M. Cunningham Jr., Chicago; editor, The MODERN HOSPITAL.

Rev. John J. Flanagan, S.J., St. Louis; executive director, Catholic Hospital Association.

Arthur S. Flemming, Washington, D. C.; secretary, Department of Health, Education and Welfare.

Edmund Fitzgerald, Milwaukee; president, United Hospital Fund of Milwaukee County.

Maurice Goldblatt, Chicago; chairman of the board, University of Chicago Cancer Research Foundation.

Paul R. Hawley, M.D., Chicago; the director, American College of Surgeons.

Emanuel Hayt, New York; attorney.

Richard M. Jones, Northbrook, Ill.; director, Blue Cross Commission of the American Hospital Association.

Charles F. Kettering, Dayton, Ohio; director, Sloan-Kettering Institute for Cancer Research, New York; director, Miami Valley Hospital, Dayton.

Arthur Mag, Kansas City, Mo.; president, board of directors, The Menorah Medical Center.

Maurice J. Norby, Glen Ellyn, Ill.; deputy director, American Hospital Association.

Herluf V. Olsen, Hanover, N. H.; professor, Amos Tuck School of Business Administration, Dartmouth College.

Andrew Pattullo, Battle Creek, Mich.; director, division of hospitals, W. K. Kellogg Foundation.

W. Douglas Piercey, M.D., Toronto,

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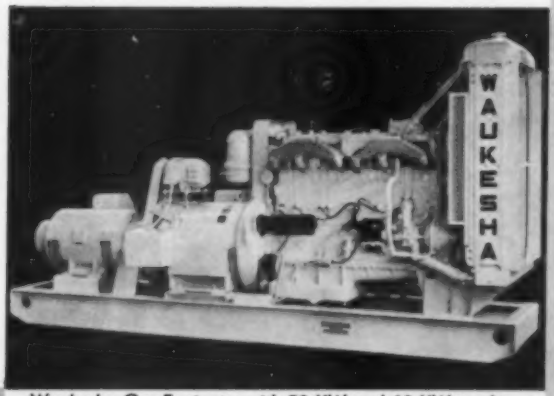
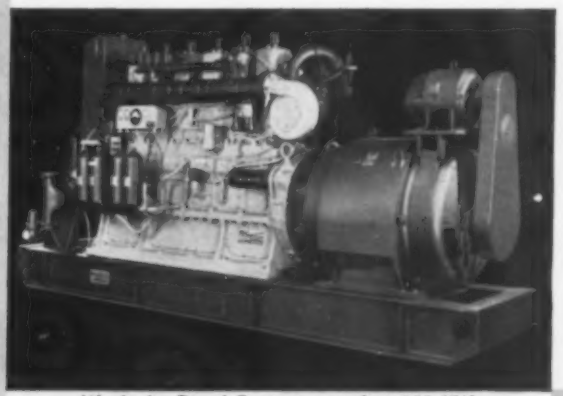


Waukesha Gas Enginator with 50 KW and 60 KW tandem generators for St. Catherine's Hospital—Kenosha, Wisconsin



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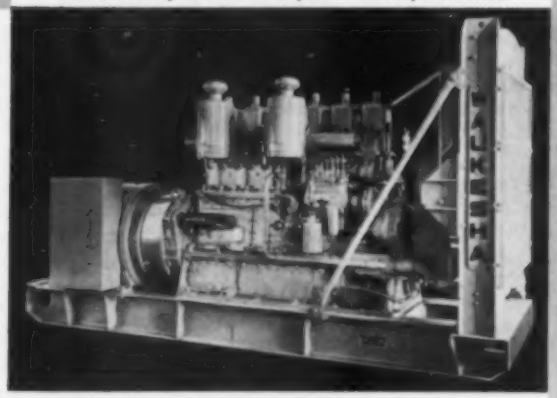
Waukesha Diesel Enginator rated at 250 KW for the Fresno County General Hospital—Fresno, California



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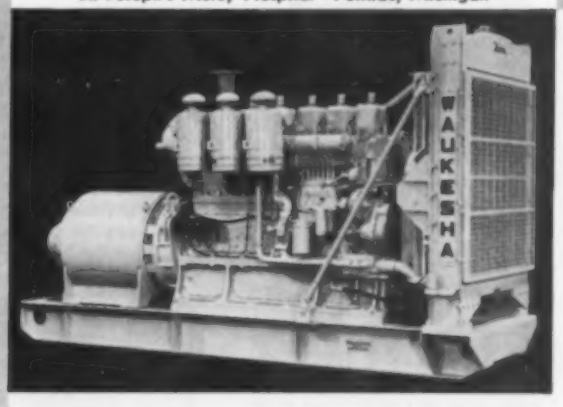
Waukesha Diesel Enginator rated at 300 KW for St. Joseph's Mercy Hospital—Pontiac, Michigan



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Ont.; executive director, Canadian Hospital Association.

Maj. Gen. Paul I. Robinson, Washington, D. C.; executive director, Office for Dependents' Medical Care.

F. Burns Roth, M.D., Regina, Sask.; deputy minister, Saskatchewan Department of Public Health.

John T. Ryan Jr., Pittsburgh; member, board of directors, Pittsburgh, Children's, Kane and Mercy hospitals.

Sir Arthur Stevenson, Melbourne, Australia; architect, Stevenson and Turner.

Col. Florence Turkington, New York; secretary, hospital division, Women's Social Service Department, The Salvation Army.

Edward L. Turner, M.D., Glenview, Ill.; secretary, A.M.A. Council on Medical Education and Hospitals.

Homer Wickenden, New York; secretary, National Health and Welfare Retirement Association, Inc.

Kenneth Williamson, Washington, D. C.; director, Washington Service Bureau, A.H.A.

Simons Is New President of Hospital Industries

CHICAGO.—At a record shattering Hospital Industries' Association meeting Roland F. Simons, Ethicon, Inc., was installed as president. Held here August 19 in the Stock Yard Inn, the meeting resulted in the election of the following officers for 1958-1959: vice-president, president-elect, Harry DeWitt, American Hospital Supply Corporation; vice-president, treasurer, Robert H. Brown, Becton, Dickinson & Co.

New members elected to the board of directors were: Earl Brenn, Huntington Laboratories, Inc., Parker B. Francis III, Puritan Compressed Gas Corp., and Burleigh Jennings, Meinecke & Co., Inc. Continuing on the board of directors are: Reginald G. Bates, J. Sklar Manufacturing Co.; Robinson Bosworth Jr., Will Ross, Inc.; Robert H. Brown; John H. Castle Jr., Wilmot Castle Co.; C. Kenneth Coty, Clay-Adams, Inc.; Harry DeWitt; Ray Hausted, Hausted Manufacturing Co.; L. J. Paxton, Simmons Company; Roland F. Simons, and Harris L. Willits, C. R. Bard, Inc.

Hospital Industries' Association members blueprinted plans for the most dynamic program in the organization's history for the coming year. H.I.A. will place major emphasis on providing additional service to the hospital associations across the country to aid them in their programs of assistance to the nation's hospitals.

Hospital Industries' Association is comprised of the leading manufacturers and distributors of hospital supplies and equipment. The past year brought 22 new members into the association, the largest number ever to join in a single year.

Grand prize winners at the third annual Hospital Industries' Association technical exhibits competition held at the A.H.A. convention here were the American Sterilizer Co. (for booths over 200 square feet), and the Crane Company (for booths 200 square feet and under). Receiving awards for their companies at ceremonies held in the huge Exhibit Hall at the International Amphitheatre were Harry M. Tompkins for the American Sterilizer Co., and B. F. Bowles for the Crane Company.

Honorable mention winners for booths over 200 square feet were the St. Charles Manufacturing Company and McKesson & Robbins, Inc. Honorable mention winners for booths 200 square feet and under were the Dixie Cup Division of the American Can Co., and the B. F. Goodrich Company, Plastic Products Division.

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ABOUT PEOPLE

(*Continued From Page* 98)

Irving Gottsegen and **Charles G. Marion,** assistant directors of Montefiore Hospital, New York, have been promoted to associate directors. Mr. Gottsegen will be responsible for professional services and Mr. Marion will be in charge of the hospital's building

Irving Gottsegen

Charles G. Marion

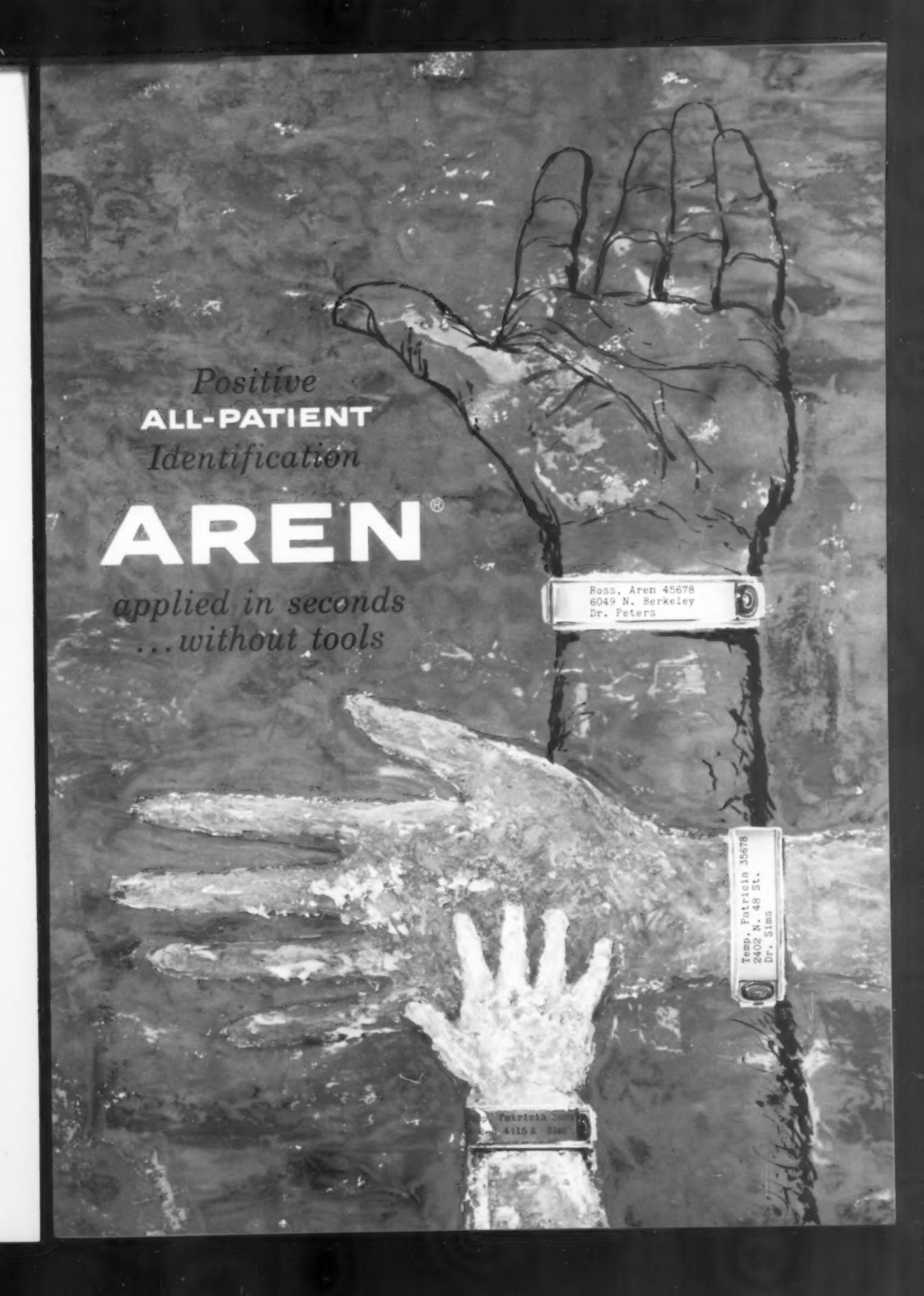
program and nonprofessional services. Mr. Gottsegen, head of the hospital's Westchester Division for eight years, joined the hospital staff in 1946. Mr. Marion went to Montefiore in 1956 after serving as executive director of the Jewish Hospital of Brooklyn, N.Y.

Sister M. Theophane

Sister M. Theophane, treasurer of St. John's Hospital, Cleveland, has been appointed administrator. She will succeed **Sister M. Mercia,** who has headed the hospital since 1952. Sister Theophane has served as general treasurer and assistant to the superior-general of the Sisters of Charity of St. Augustine, and also has been treasurer of St. Vincent Charity Hospital, Cleveland, and St. Thomas Hospital, Akron, Ohio.

Dr. Lester H. Rudy, superintendent of Galesburg State Research Hospital, Galesburg, Ill., has been named superintendent of the $9.4 million Illinois State Psychiatric Institute, a part of the Chicago Medical Center. Dr. Rudy will have charge of organizing the staff of the hospital, which is to be opened in 1959 for psychiatric training and research. **Dr. Thomas T. Tourlentes,** assistant superintendent at Galesburg since 1954, will succeed Dr. Rudy there. At the same time it was announced that **Dr. Percival Bailey** will become director of research and **Dr. Jules H. Masserman** will be director of education at the new Chicago institu-

(*Continued on Page* 206)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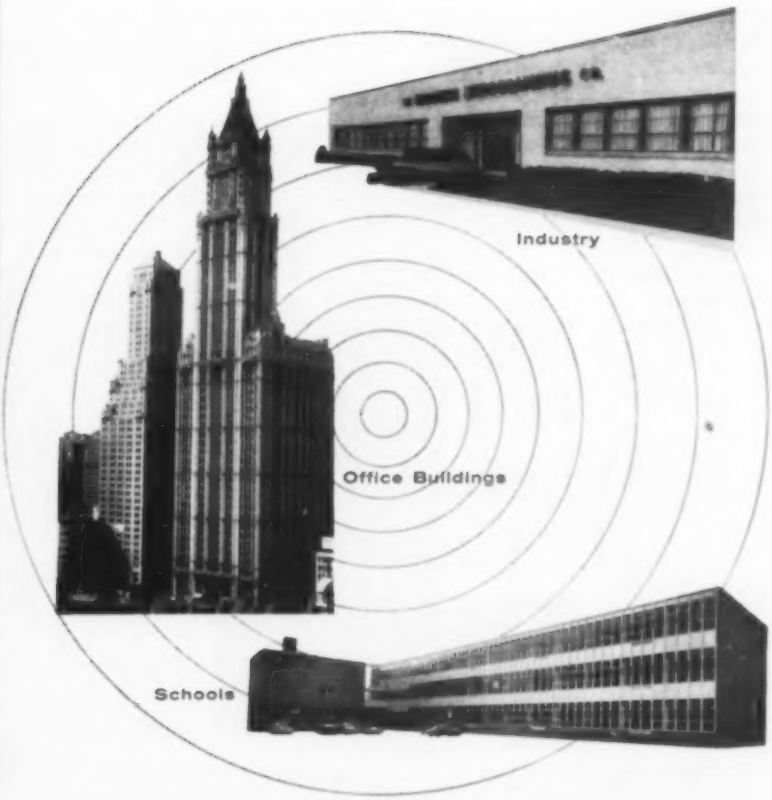

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(Continued From Page 202)

tion. Dr. Bailey is professor of neurology and neurological surgery and clinical professor of psychiatry at the University of Illinois. He is acting executive director of the Illinois Psychiatric Training and Research Authority. Dr. Masserman is professor of nervous and mental diseases at Northwestern University and also serves as psychiatric consultant to the World Health Organization.

John K. Miles Jr. has been appointed administrative assistant at Vanderbilt University Hospital, Nashville, Tenn.

Richard Sanders has been appointed administrative assistant for Dallas County Hospital District, Dallas. Mr. Sanders is a graduate of Northwestern University's hospital administration course.

John O. Tucker has been named night administrator at University Hospital and Hillman Clinic, Birmingham, Ala. Mr. Tucker served his administrative residency at the hospital and received his master's degree in hospital administration from Northwestern University. He is a graduate of Howard College.

Lester L. Lamb

Lester L. Lamb has been appointed administrator of Hampshire Memorial Hospital, Romney, W. Va. The 40 bed general hospital is scheduled to be opened this fall. Mr. Lamb is a hospital administration graduate of Medical College of Virginia and served his administrative residency at Medical College of Virginia, Shenandoah County Memorial Hospital, Woodstock, Va., and Washington County Hospital, Hagerstown, Md.

Nathan E. Morgan, former administrator of Fifth Avenue General Hospital, Huntsville, Ala., has been appointed administrator of Cookeville General Hospital, Cookeville, Tenn., succeeding the late **Jesse W. Cofty.** Mr. Cofty died unexpectedly in June at the age of 42.

Joseph J. Hines

Joseph J. Hines recently was appointed assistant administrator of Truesdale Hospital, Fall River, Mass. Mr. Hines received his master's degree in hospital administration from Columbia University's graduate school.

Charles T. Davis has been appointed administrator of Terry County Hospital, Brownfield, Tex. Ownership of the hospital, formerly known as Treadaway-Daniell Hospital, was transferred to the county early this summer. Mr. Davis previously was business manager of Midland Memorial Hospital, Midland, Tex.

Stanley Volga, administrator of Myrtue Memorial Hospital, Harlan, Iowa, since 1952, has resigned. He will be succeeded by **Cletus Turnbach,** laboratory technician at the hospital.

W. E. Middleton has resigned as administrator of Polk County Memorial Hospital, Mena, Ark. He will be succeeded by **Merle Watson.**

Stuart A. Shortt has been named administrator of Perry County Memorial Hospital, Perryville, Mo. Formerly, he was administrator of Massac Memorial Hospital, Metropolis, Ill.

Lilyan C. Zindell, administrator of Perry County Memorial Hospital, Perryville, Mo., for eight years, has resigned to become consultant for Madi-

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son County Memorial Hospital, a general hospital and geriatric unit to be built in Fredericktown, Mo. When the units are completed, Miss Zindell will become executive director.

Carroll W. Ogren has been named assistant administrator at Washoe Medical Center, Reno, Nev. Mr. Ogren, a hospital administration graduate of Washington University, served as administrative resident at the hospital last year.

Jerry B. Boyle

Jerry B. Boyle has been named administrative assistant at University Hospitals of Cleveland. Mr. Boyle, a graduate of the hospital administration program at the University of Chicago, completed his residency at University Hospitals. He is also a graduate of the University of Missouri.

E. D. Cramer has returned as administrator of Wilson County Hospital, Neodesha, Kan., from Kansas City, Mo., where he was business manager of Children's Mercy Hospital. Before going to Kansas City, Mr. Cramer served as administrator at Neodesha for three and one-half years.

George Lerrigo, administrator of Sylacauga Hospital Sylacauga, Ala., has resigned. **William F. Tucker,** formerly administrator of Blount Memorial Hospital, Oneonta, Ala., has been named acting administrator, succeeding Mr. Lerrigo.

Peter J. Alexander has been appointed administrator of the new Parkview Memorial Hospital, now under construction at Arlington, Calif. Mr. Alexander is a hospital administration graduate of Northwestern University.

James Moses, former administrator of Pawnee Municipal Hospital, Pawnee, Okla., has been named administrator of Cushing Municipal Hospital, Cushing, Okla. He succeeds **A. B. Whiteley,** who resigned to build a nursing home in Cushing.

Department Heads

Olga C. Benderoff has been named director of nursing at University Hospitals of Cleveland and professor of nursing at Western Reserve University's Frances Payne Bolton School of Nursing. Miss Benderoff, who will assume her new duties Jan. 1, 1959, has been director of nursing at Cuyahoga

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County Hospital, Cleveland since 1955. She will succeed **Ann C. Deeds,** who resigned in July.


Earl C. Wolf

Earl C. Wolf, administrative assistant and director of purchases for St. Mary's Hospital, Rochester, Minn., since 1939, has announced his retirement. Mr. Wolf will move to Ft. Lauderdale, Fla., to begin consulting work in the field of hospital stores development and purchasing, receiving, storing, issuing and inventory control. **Irvin J. Mullenbach,** formerly assistant purchasing agent and stores department manager, will succeed Mr. Wolf at St. Mary's.

John Reedy has been named business manager of Forrest General Hospital, Hattiesburg, Miss., succeeding **Clifford Johnson,** who is now administrator of Jefferson Davis County Hospital, Prentiss, Miss. Mr. Reedy is a graduate of Mississippi Southern College.

Helen Epp has been appointed chief medical record librarian at Miami Valley Hospital, Dayton, Ohio. Formerly, Miss Epp was chief medical librarian at Immanuel Hospital, Omaha, Neb., where she reorganized the department and headed it for 10 years. Miss Epp is a graduate of Immanuel Hospital School of Nursing, the University of Omaha, and the Institute for Medical Record Librarians.

Andrew Heath, assistant business executive at Caro State Hospital, Caro, Mich., has been named director of personnel at the hospital.


Mary Ann Ramsey

Mary Ann Ramsey has been appointed director of health education and public relations at Lankenau Hospital, Philadelphia. Miss Ramsey has been public relations director at Temple University Medical Center since March 1956, and she was director of public relations and volunteer services at Children's Hospital of Philadelphia prior to that.

Ben Piazza, head of the physical therapy department at Mercy Hospital-Street Memorial, Vicksburg, Miss., for nine years, has resigned to accept a similar position at University Hospital, Jackson, Miss. His successor at Mercy will be **Mrs. Max Klaus.**

Joseph Kay has been named director of personnel for Montefiore Hospital, New York. Mr. Kay, a graduate of Boston University, has been in personnel work for several years, associated with various business firms.

Veronica Mitchell has been appointed director of nursing service and education at W. W. Backus Hospital, Norwich, Conn. Miss Mitchell received her master's degree from Western Reserve University, Cleveland.

Annie Ruth Allen, R. N., has been appointed superintendent of nurses at Neshoba County Hospital, Philadelphia, Miss. Mrs. Allen is a graduate of Hotel Dieu School of Nursing, New Orleans, and was a captian in the army nurse corps.

Miscellaneous

Howard I. Wells Jr., executive secretary of the American Association for Maternal and Infant Health since 1954, has been appointed executive secretary of the Joint Council to Im-

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The Lanier Co., 2129 7th Ave. S.
Boston 15, Massachusetts
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Buffalo 10, New York
Regal Electronics, 796 Clinton
Camp Hill, Pennsylvania
John A. Morefield Company
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prove the Health Care of the Aged. Mr. Wells is a graduate of Northwestern University and did graduate study in social welfare administration at the University of Copenhagen.

Dr. Benjamin B. Wells, director of professional services at the Veterans Administration hospital in New Orleans, has been appointed to head V. A. medical education services in Washington, D. C. Dr. Wells will succeed **Dr. John C. Nunemaker,** who is leaving the V. A. to become associate secretary of the American Medical Association Council on Medical Education and Hospitals, in Chicago.

Dr. Turner Camp, chief medical officer of the Veterans Administration outpatient clinic in Los Angeles, has been named to direct the V. A.'s outpatient clinics throughout the country. He succeeds **Dr. Arthur J. Klippen** as director of clinics in the V. A. department of medicine and surgery. Dr. Klippen has been appointed director of hospitals in the same department, a position that has been vacant for some time.

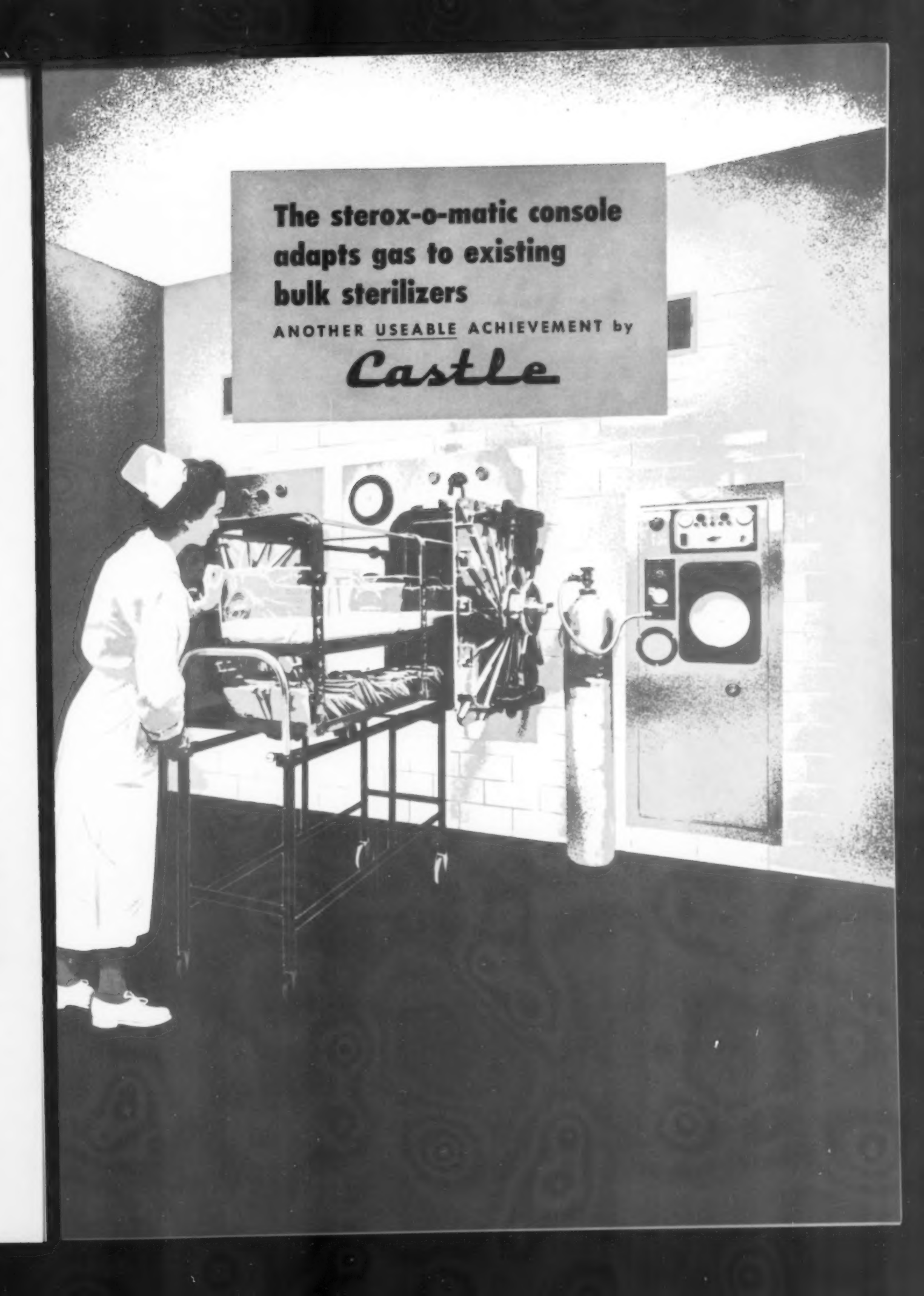
David T. Riddell has been appointed to the newly created position of fund raising director at Saint Barnabas Medical Center, Newark, N.J. The new hospital is to be erected in Livingston, N.J. Mr. Riddell is executive officer of the Hospital Research and Educational Trust of the American Hospital Association and a former assistant to the director of the A.H.A. He also served as managing editor of *Hospitals* at one time

Prof. William L. Doyle of the department of anatomy of the University of Chicago has been named associate dean of the division of biological sciences, in charge of nonclinical affairs. He will succeed the late **Dr. Merle C. Coulter.**

Edward E. James has joined the staff of Booz, Allen & Hamilton, management consultants, in the field of hospitals, health and welfare. For the last two years, Mr. James has operated his own consulting firm in Grand Rapids, Mich. Before entering the consultation field, Mr. James was administrator of Butterworth Hospital, Grand Rapids, Mich.

Richard S. Greenfield has been named assistant executive director of the New Jersey Hospital Association, succeeding **Edward A. Dougherty.** Mr. Greenfield received his master's degree in hospital administration from

(*Continued on Page* 215)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(*Continued From Page 212*)
Columbia University and served his residency at St. Luke's Hospital, Newburgh, N. Y.

Patricia C. Smith has joined the staff of the National League for Nursing as a part-time consultant in evaluation and research. Dr. Smith also is associate professor, College of Arts and Sciences, Cornell University. At the same time, its was announced that **Margaret L. Shetland** will become a staff member of the N.L.N.'s department of baccalaureate and higher degree programs on Jan. 1, 1959. She is chief nursing adviser, health division, U.S.A. operations mission to the Philippines, International Cooperation Administration. **Margaret E. Killeen** is a new field consultant for the committee on careers, Midwest region. Previously, Miss Killeen was a specialist in community organization for the New York City Housing Authority.

Dorothy Rusby, assistant director of the National League for Nursing's department of public health nursing, has been appointed director of the Visiting Nurse Association of Cleveland.

Mary F. Quarmby has been appointed assistant director of the department of baccalaureate and higher degree programs, National League for Nursing. Formerly, Miss Quarmby was instructor in psychiatric nursing, New York State University, and instructor-supervisor at Duke University Hospital, Durham, N.C. **Mary Elizabeth Kobelson** has joined the staff of the N.L.N. department of diploma and associate degree programs, as assistant director.

Deaths

Morris Kurtzon, founder and first president of Mt. Sinai Hospital, Chicago, died July 24 at the age of 83. Mr. Kurtzon was president of Mt. Sinai for 26 years and chairman of its board of directors for three years. At the time of his death he was honorary president. The main building of the hospital, which was opened in 1919, is named for him. Mr. Kurtzon was a former director of the Chicago Hospital Council.

Dr. Harry Jennings Worthing, director of Pilgrim State Hospital, West Brentwood, N.Y., died in July of a heart attack. He was 70. Dr. Worthing had been head of the hospital, described as the world's largest mental institution, since 1937. He served at several other state mental hospitals before going to Pilgrim State.

John Maxwell, 49, purchasing agent of Waterbury Hospital, Waterbury, Conn., died suddenly in July. Mr. Maxwell first joined the hospital staff in 1931, serving in various positions. He was appointed purchasing agent five years ago.

Murray Schnee, purchasing executive at Montefiore Hospital, New York, died recently. Mr. Schnee had been on the Montefiore hospital staff for 37 years.

Dr. Neva R. Deardorff, statistical expert in social welfare and health work for more than 40 years, died August 21 of a heart attack. She was 71. Dr. Deardorff was a founder of the Health Insurance Plan of Greater New York and served as its director of research and statistics for eight years. For 20 years she was director of the research bureau of the Welfare Council of New York and she also has served as consultant on medical care statistics to the Council of Jewish Federations and Welfare Funds. She was the author of several books and a frequent contributor to journals in the health and welfare fields.

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2. Shows you how special problems have been solved, using actual examples. Presents 44 separate new laboratory projects, in all areas of scientific research. These buildings are in all areas of the country, and are owned by corporations, universities, and government agencies. Each is thoroughly described in text, photographs, plans and drawings.

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BRIEF SUMMARY OF CONTENTS

1. PLANNING THE LABORATORY

An 18-page outline of fundamentals by Charles Haines of Voorhees, Walker, Smith and Smith. A study of laboratory equipment as it affects design. Analyses of five plot plans of research centers, including RCA laboratories at Princeton, N. J., and Armstrong Cork Co. in Lancaster, Penna. All 5 shown in numerous plans and drawings.

2. NUCLEAR LABORATORIES

Defines CC (concentrate and confine) and DDD (dilute, disperse, decontaminate) theories. Studies architectural requirements of cyclotrons, bevatrons, and other types of reactors and accelerators. Emphasis on shielding and personnel safety. Many AEC and university buildings shown in photographs and drawings. Much of this information only recently declassified by government.

3. INDUSTRIAL LABORATORIES

The largest section in the book. A total of 20 biological, engineering, chemical, and electronic laboratories. Includes a GE laboratory that won congratulations from its residential neighbors, Union Oil's 14-building complex, with all buildings connected by service tunnels, Corn Products' huge research center with complete pilot plant, and many more. All buildings described thoroughly in text, photographs, and drawings and plans.

4. INSTITUTIONAL LABORATORIES

Owned by government agencies and universities, with the emphasis on pure research. An entire new postgraduate school of research for the Navy at Monterey, Calif. is shown—maximum sharing of facilities by diverse departments and built on a very tight budget. Also a chemical engineering building at the University of Minnesota built on the modular plan, an engineering building at U.C.L.A. with a floor live-load of 600 lb per sq ft, and a dairy laboratory at the University of Wisconsin where a germ-free atmosphere and ease of cleaning were pressing problems.

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COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Statler Hotel, Boston, Oct. 13-16.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Institutes: 26th Chicago, University of Chicago, Sept. 2-12.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Members Conferences: Region 11, Kansas City, Mo., Oct. 20-24; Region 10, Minneapolis, Oct. 27-31; Region 1, Boston, Nov. 10-14; Region 8, East Lansing, Mich., Nov. 17-21.

AMERICAN COLLEGE OF SURGEONS, Clinical Congress, Hilton Hotel, Chicago, Oct. 6-10.

AMERICAN DIETETIC ASSOCIATION, Bellevue Stratford and Benjamin Franklin Hotels, Philadelphia, Oct. 21-24.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler Hotel, Boston, Oct. 26-29.

ARIZONA HOSPITAL ASSOCIATION, Westward-Ho Hotel, Phoenix, Nov. 13, 14.

BRITISH COLUMBIA HOSPITALS' ASSOCIATION, Hotel Vancouver, Vancouver, Oct. 28-31.

CALIFORNIA HOSPITAL ASSOCIATION, Biltmore and Miramar Hotels, Santa Barbara, Oct. 22-24.

COLORADO HOSPITAL ASSOCIATION, Cosmopolitan Hotel, Denver, Oct. 9, 10.

HOSPITAL ASSOCIATION OF RHODE ISLAND, Sheraton-Biltmore Hotel, Providence, Oct. 21.

IDAHO HOSPITAL ASSOCIATION, Elks Temple, Boise, Oct. 20, 21.

INDIANA HOSPITAL ASSOCIATION, Indiana Student Union Building, Indianapolis, Oct. 8, 9.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 13, 14.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Nov. 3-5.

MINNESOTA HOSPITAL ASSOCIATION, Lowry Hotel, St. Paul, Nov. 7.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Heidelberg, Jackson, Oct. 23, 24.

MISSOURI HOSPITAL ASSOCIATION, President Hotel, Kansas City, Nov. 19-21.

MONTANA HOSPITAL ASSOCIATION, Havre, Sept. 15, 16.

NEBRASKA HOSPITAL ASSOCIATION, Sheraton-Fontenelle Hotel, Omaha, Oct. 23, 24.

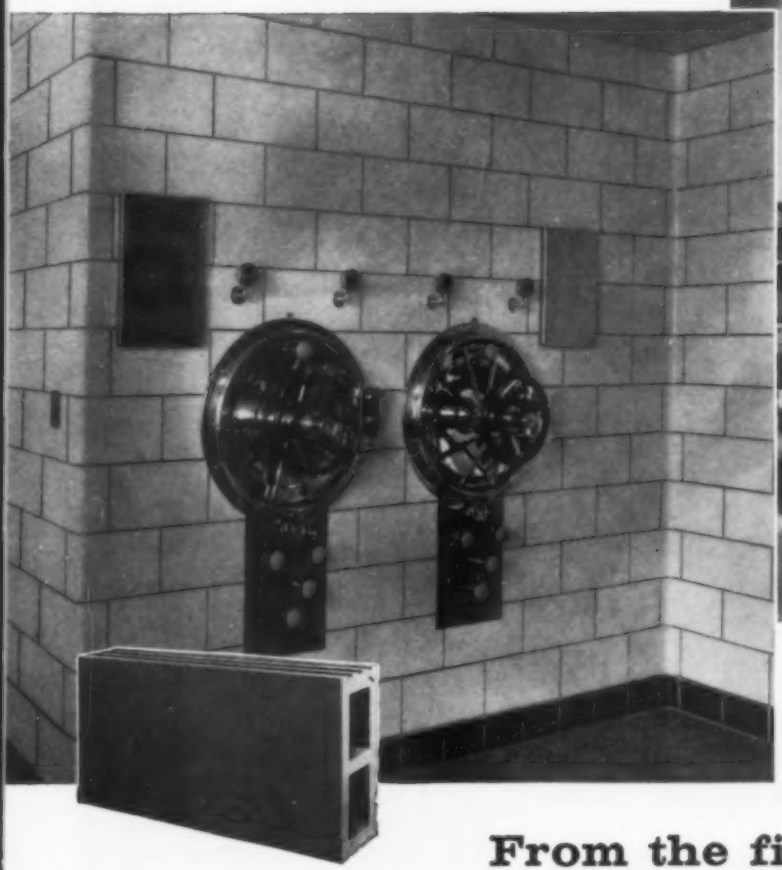
OKLAHOMA HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 6, 7.

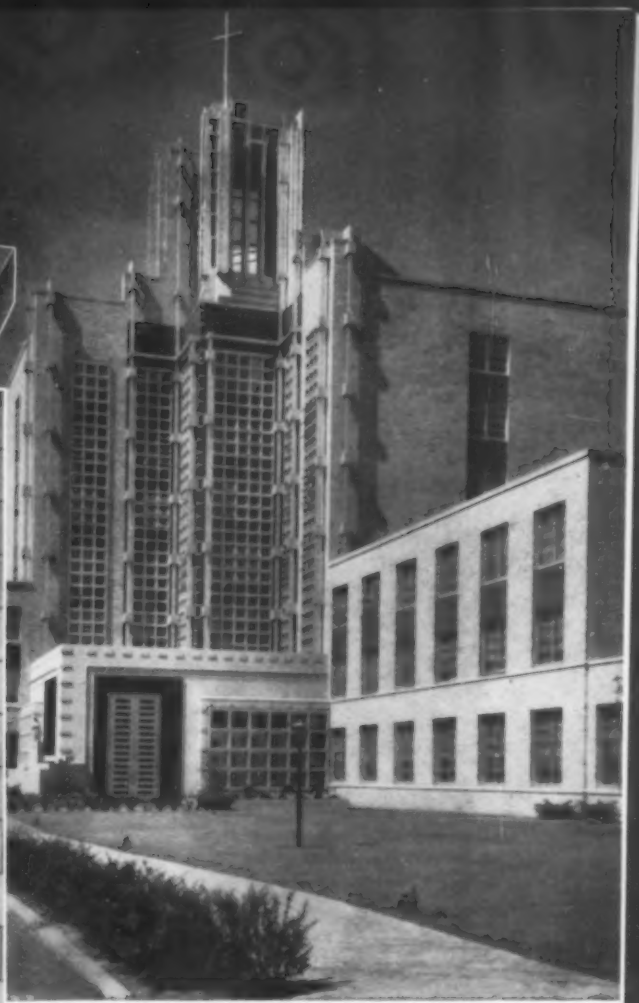
OREGON ASSOCIATION OF HOSPITALS, Gearhart Hotel, Gearhart, Oct. 13, 14.

VERMONT HOSPITAL ASSOCIATION, Hotel Vermont, Burlington, Oct. 8, 9.

(Continued on Page 220)

St. Elizabeth's Hospital, Belleville, Illinois
Architect—Henry R. Slaby, A.I.A., Milwaukee, Wisconsin
Material—Natco Buff Roman Face Brick





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(*Continued From Page 218*)

VIRGINIA HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Nov. 14-16.

WASHINGTON STATE HOSPITAL ASSOCIATION, Winthrop Hotel, Tacoma, Oct. 15, 16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Daniel Boone Hotel, Charleston, Oct. 15-18.

WYOMING HOSPITAL ASSOCIATION, Memorial Hospital of Natrona County, Casper, Oct. 16, 17.

1959

ALABAMA HOSPITAL ASSOCIATION, Admiral Semmes Hotel, Mobile, Jan. 23, 24.

AMERICAN HOSPITAL ASSOCIATION, The Coliseum, New York, Aug. 24-27.

AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, Sheraton-Palace Hotel, San Francisco, March 30-April 1.

ASSOCIATION OF OPERATING ROOM NURSES, Shamrock-Hilton Hotel, Houston, Feb. 9-11.

ASSOCIATION OF WESTERN HOSPITALS, Hotel and Motel Utah, Salt Lake City, May 4-7.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 8-10.

CATHOLIC HOSPITAL ASSOCIATION, Kiel Auditorium, St. Louis, June 1-4.

GEORGIA HOSPITAL ASSOCIATION, Bon Air Hotel, Augusta, March 5, 6.

KENTUCKY HOSPITAL ASSOCIATION, Phoenix Hotel, Lexington, Mar. 31-April 2.

MAINE HOSPITAL ASSOCIATION, Hotel Samoset, Rockland, June 2, 3.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D. C., Oct. 26-28.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N. J., May 20-22.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 1-3.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 23-25.

OHIO HOSPITAL ASSOCIATION, Deshler-Hilton Hotel and Veterans Memorial Auditorium, Columbus, April 6-9.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta-Biltmore Hotel, Atlanta, April 8-10.

TENNESSEE HOSPITAL ASSOCIATION, Andrew Jackson Hotel, Nashville, May 7-8.

TEXAS HOSPITAL ASSOCIATION, Shamrock-Hilton Hotel, Houston, May 12-14.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 27-29.

UPPER MIDWEST HOSPITAL CONFERENCE, St. Paul Auditorium, St. Paul, May 13-15.

Public Mental Hospitals Report Drop in Patient Census for Second Year

NEW YORK.—Patient population in public mental hospitals has declined for the second straight year, the American Psychiatric Association and the National Association for Mental Health have reported.

The year-end report of the two groups also showed that the hospitals admitted more new patients, readmitted more former patients, discharged more patients, and spent more money on each patient.

The patient census dropped from 551,390 to 548,563 in 1957, the report said. First admissions increased by 3.9 per cent, readmissions by 9.2 per cent, and discharges by 9.2 per cent. The over-all resident patient decrease was 0.5 per cent.

Expenditures per patient increased from $3.27 per day to $3.64, a jump of 11 per cent.

Full-time employes in public mental hospitals rose from 153,715 to 162,885, a 6 per cent increase.

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Size: 70" x 90" • Fine Quality • All Cotton
Heavy Weight Bleached White • Soft, Full Nap
Minimum Shrinkage

PACKED: 48 PER CARTON

1 CARTON (48 Blankets)	2 CARTONS OR MORE (96 Blankets or more)
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DIETITIAN—Experienced, Canadian, desires position as chief in hospital of 300-beds or less; preferably west coast but will definitely consider any western location. Reply MW 38, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

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Telephone: RAndolph 6-5682

ADMINISTRATOR—MHA; ACHA Nominee; 2 years, administrator, 50-bed hospital; 6 years, assistant administrator, 375-bed hospital; seeks administratorship, 100-bed or more hospital; prefers midwest; Age 34.

ASSISTANT ADMINISTRATOR—A.H.A; BA, Business Administration; MS, Hospital Administration; 10 months, medical service and purchasing, 750-bed, JCAH hospital; seeks assistant administratorship, hospital 100-beds and up; age 26.

ANESTHESIOLOGIST—Trained, university hospital; completing military tour; seeks chiefship, larger hospital, temporate climate; early 30's; Diplomate.

EXECUTIVE HOUSEKEEPER—Past 3 years full charge, large psychiatric hospital; seeks general hospital appointment; California, others west and southwest.

EXECUTIVE HOUSEKEEPER—Male; stable employment record includes 10 years in full charge very large general hospital system; qualified assume laundry, linen functions also; seeks large hospital appointment; late 40's.

WOODWARD—*Continued*

PATHOLOGIST—9 years, assistant and associate professor, important medical schools and assistant and chief, pathology, their graduate hospitals; now completing Fullbright scholarship; Diplomate, anatomy; immediately available; eary 40's.

RADIOLOGIST—Trained radiology, university hospital; also 2 years, residency, surgery; 5 years, general practice before specializing; 10 months; assistant chief, radiology, large hospital and on faculty, medical school; A.O.A.; Diplomate, diagnostic, therapeutic and nuclear medicine; late 30's.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 N. MICHIGAN AVENUE, CHICAGO

ADMINISTRATOR—MHA; administrative residency, teaching hospital; 6 years, associate administrator, 500-bed university affiliated hospital; Member, ACHA.

ANESTHESIOLOGIST—Diplomate, American Board; 9 years, department anesthesiology, well known clinic, on staff medical school.

PATHOLOGIST—Diplomate, FACP; eight years director of pathology, 350-bed general hospital, consultant to several others.

RADIOLOGIST—Training in radiology, teaching hospital; 3 years, private and hospital practice; Diplomate.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—M.S., M.H.A. Degree, 1954; 4 years administrator; 120-bed hospital; midwest; desires a change.

ASSISTANT ADMINISTRATOR—B.S. Degree, Business Administration; 4 years credit-manager 300-bed hospital; 4 years business manager.

ASSISTANT ADMINISTRATOR—B.B.A. Degree, 1953; M.H.A. Degree, 1955; 2 years administrative assistant; 300-bed New Jersey hospital.

COMPTROLLER—B.B.A. Degree, 1950; 8 years chief accountant, and purchasing assistant; 200-bed Ohio hospital; available.

CHIEF PHARMACIST—Completed a year's course eastern teaching hospital; 3 years assistant director, pharmacy service; 400-bed hospital.

EXECUTIVE HOUSEKEEPER—Home Economic and institutional management courses; 4 years experience; 175-bed hospital.

(Continued on page 224)

POSITIONS OPEN

ADMINISTRATOR—To be employed January 1, 1959; 50-bed Hill Burton Hospital; state qualifications, experience and salary expected. Reply Sumner County Hospital Commission, Sumner County Court House, Gallatin, Tennessee.

ANESTHESIOLOGIST—Wanted to work either "free lance" in city with two hospitals, or work for one hospital in charge of department. Reply MO 234, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST—Nurse; in 66-bed general hospital; expansion to 104-beds under way; located in an exclusive suburb of Chicago; Chicago North Shore & Milwaukee and Chicago & Northwestern trains serve the community; modern anesthesia equipment; three anesthetists in department; good salary, four weeks vacation, other benefits. Apply Personnel Director, Lake Forest Hospital, Lake Forest, Illinois.

ANESTHETIST—Fourth; needed for attractive position in modern 112-bed fully accredited hospital; active surgical schedule; starting salary $496.00 monthly; liberal yearly increases; numerous employee benefits; pleasant living in small community environment; commuting time — 10 minutes per day; rentals low. Write Alan B. Campbell, Administrator, Richland Memorial Hospital, Olney, Illinois.

ANESTHETIST—Nurse; R.N.A. for 215-bed hospital; excellent surroundings and personnel policies; $6300.00 starting salary with time and merit increments. Reply J. A. Anderson, Superintendent, Lutheran Hospital, Fort Dodge, Iowa.

ANESTHETIST—R.N.A.; for nearly new 114-bed general hospital; hospital cafeteria, energetic medical staff; excellent starting salary with time and merit increases; liberal employee benefit program or free lance basis. Write administrator, Coffeyville Memorial Hospital, Coffeyville, Kansas.

ANESTHETIST—Nurse; opening in obstetric department; 11:00 p.m. to 7:30 a.m.; liberal employee benefit program includes vacation, sick pay, and holidays. Write Personnel Department, St. Joseph Mercy Hospital, 900 Woodward Avenue, Pontiac, Michigan.

ANESTHETIST—Nurse; Sage Memorial Hospital (60-bed hospital, 56 miles from Gallup, New Mexico), Ganado, Arizona; single woman, graduate of approved school of nursing and anesthesia; experience preferred. Write stating qualifications. United Presbyterian Church in U.S.A., Board of National Missions, Room 703, 156 Fifth Avenue, New York 10, N.Y.

ANESTHETIST—Nurse; to join Ob-Gyn anesthesia staff; 250-bed general hospital; 40 hour week, excellent salary, months vacation. Write Assistant Administrator, Highland Hospital, Rochester, New York.

ANESTHETISTS—Wanted several nurse anesthetists for enlarged anesthesia department in a 250-bed general hospital located in a resort town eight miles from famous Wrightsville Beach, North Carolina. Write James Walker Memorial Hospital, Wilmington, North Carolina.

classified advertising

POSITIONS OPEN

ANESTHETIST—Nurse; Texas Gulf Coast resort area; 250-bed general hospital with M.D.'s heading department; two vacancies; salary beginning $450 with increment increases. Reply Dr. R. J. Sigler, Memorial Hospital, Corpus Christi, Texas.

ANESTHETIST—Nurse; $400-$600 per month; excellent medical staff; 200-bed hospital; fringe benefits, health, life, retirement insurance paid vacation-sick leave; hospital cafeteria, nurses' home accommodations. Contact E. J. Berg, Business Manager, Gundersen Clinic, La Crosse, Wisconsin.

DIETITIAN—Staff; Eastern coast Medical Center; 50 miles from New York City; 350-bed capacity with expansion in process; therapeutic diet work; require BS degree in food and nutrition; ADA membership not necessary; salary open. Reply Box MO 238, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIAN—Opening in 400-bed hospital which is adding 120-bed rehabilitation unit; excellent opportunity in therapeutic or administrative work for A.D.A. registered person; salary commensurate with training and experience; liberal benefits. Apply Personnel Director, Iowa Methodist Hospital and Raymond Blank Memorial Hospital for Children, Des Moines, Iowa.

DIETITIAN—Graduate; administrative experience helpful; excellent pay, quarters, vacation and retirement plan. Write Sunshine Hospital, Grand Rapids 3, Mich.

DIETITIANS—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN— A.D.A. or equal, full charge of department in 55-bed general hospital; modern kitchen, excellent conditions, salary open. Apply Administrator, Lakeview Memorial Hospital, Bath, New York.

DIETITIANS—Staff; one teaching; one therapeutic; A.D.A. members, hospital recently expanded to 450-bed, located in residential district; approved by J.C.H.A.; dietary facilities entirely new and air conditioned; dietetic program integrated with N.L.N. approved school of nursing, affiliated with Medical Research Institute; 40 hour week, board personnel policies and benefits; salary open. Apply Miss Rosemary E. Brown, Director of Dietetics, The Toledo Hospital, Toledo 6, Ohio, or call Greenwood 2-1121.

(Continued on page 226)

DIETITIAN—Chief; A.D.A.; to be in charge of food service for 500-bed general hospital. Apply Harriette S. Oeftiger, Personnel Director, Wilson Memorial Hospital, Johnson City, New York.

DIETITIAN—Staff; A.D.A. or equal; 250-bed general hospital; JCAH approved; excellent personnel policies; salary in accordance with experience. Apply Personnel Department, Chester Hospital, Chester, Pennsylvania.

DIETITIAN—Assistant; excellent opportunity to gain administrative and therapeutic experience in 170-bed general hospital; JCAH approved; 40 hour week; salary open. Apply Administrator, Yakima Valley Memorial Hospital, Yakima, Washington.

DIRECTOR—Assistant: occupational therapy registered; modern tuberculosis hospital, with affiliation program; five day week, 40 hour, paid vacations, 7 holidays, sick leave, social security; excellent opportunity for progressive administrator. Resume to Director, Occupational Therapy, Emily P. Bissell Hospital, 3060 Newport Gap Pike, Wilmington 8, Delaware.

DIRECTOR—Medical records department; immediate opening; 446-bed general hospital; good salary and personnel policies; opportunity to work with professional activity study. Write Mr. J. M. Dunlop, Administrator, Bridgeport Hospital, Bridgeport, Connecticut.

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when the RIXSON *automatic* opens and closes the door

Whether the **RIXSON *automatic*** is actuated by mat (as illustrated), or by floor or wall switch, it offers many new advantages of safety and function. Busy hospital personnel with carts, trays or wheel stretchers need not stop to open doors, nor bother to close them.

The **RIXSON *automatic*** opens the door by hydraulic power and closes the door by hydraulic power—no springs required. It is completely concealed in the floor—no arms or other hardware are visible. And even the safety is automatic.

If a person steps on safety mat after door is in opening swing, door will not strike him, but will STOP.

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POSITIONS OPEN

DIRECTOR—Clinical; Board Diplomate in Psychiatry; to head challenging training and research programs in 3000-bed state mental hospital; approved for 3 years residency training in psychiatry; position open September 1, 1958; eight room house available at nominal rate; retirement plan and many other excellent benefits; salary $12,600 to $16,383; annual increments of $630; near New York City and Central Jersey Shore area. Apply J. Berkeley Gordon, Marlboro, New Jersey.

DIRECTOR OF NURSING SERVICE—Expanding 300-bed West Coast hospital, metropolitan location; salary open; desire candidate with 2 years demonstrated progressive administrative experience plus MA in Nursing Administration, or 6 years comparable experience. Write MO 218, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSING SERVICE—320-bed general hospital; fully approved, Joint Commission, interns and residents, school of nursing; prefer not over 45, Protestant, degree, experience in nursing service; salary potential — $4,780.00 to $7,072.00 range, fringe benefits substantial. Apply Superintendent, Bethesda Hospital, Cincinnati 6, Ohio.

DIRECTOR OF NURSING SERVICE AND EDUCATION—In accredited 500-bed hospital; diploma school with 200 students; affiliated in freshman year with Muhlenberg College; Master's degree and experience as assistant essential; starting salary commensurate with background and experience. Apply Assistant Superintendent, Allentown Hospital Allentown, Pennsylvania.

DIRECTOR OF NURSES—Experience preferred, and one general duty nurse, for a 40 to 50-bed hospital at Amery, Wisconsin, 60 miles east of St. Paul-Minneapolis; salary open. Please contact Administrator.

INSTRUCTORS—Clinical; needed in the following categories: medical-surgical nursing, days; obstetrical nursing, afternoons; pediatric nursing, nights; integrated program; affiliated with Drake University; 200 students in school; 400-bed, fully approved, non-profit hospital; minimum qualifications: B.S. degree, preferably in nursing education; salary open; 40 hour work week; 20 working days vacation; sick benefits. Apply Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

INSTRUCTOR—Psychiatric nursing; progressive State Hospital with affiliate nursing program; starting salary dependent upon academic qualifications, experience and personal qualifications; starting range from $4140 to $8100 plus self-maintenance, liberal sick time, holidays, paid vacation. Write Dr. J. O. Cromwell, Superintendent, Mental Health Institute, Independence, Iowa.

(Continued on page 228)

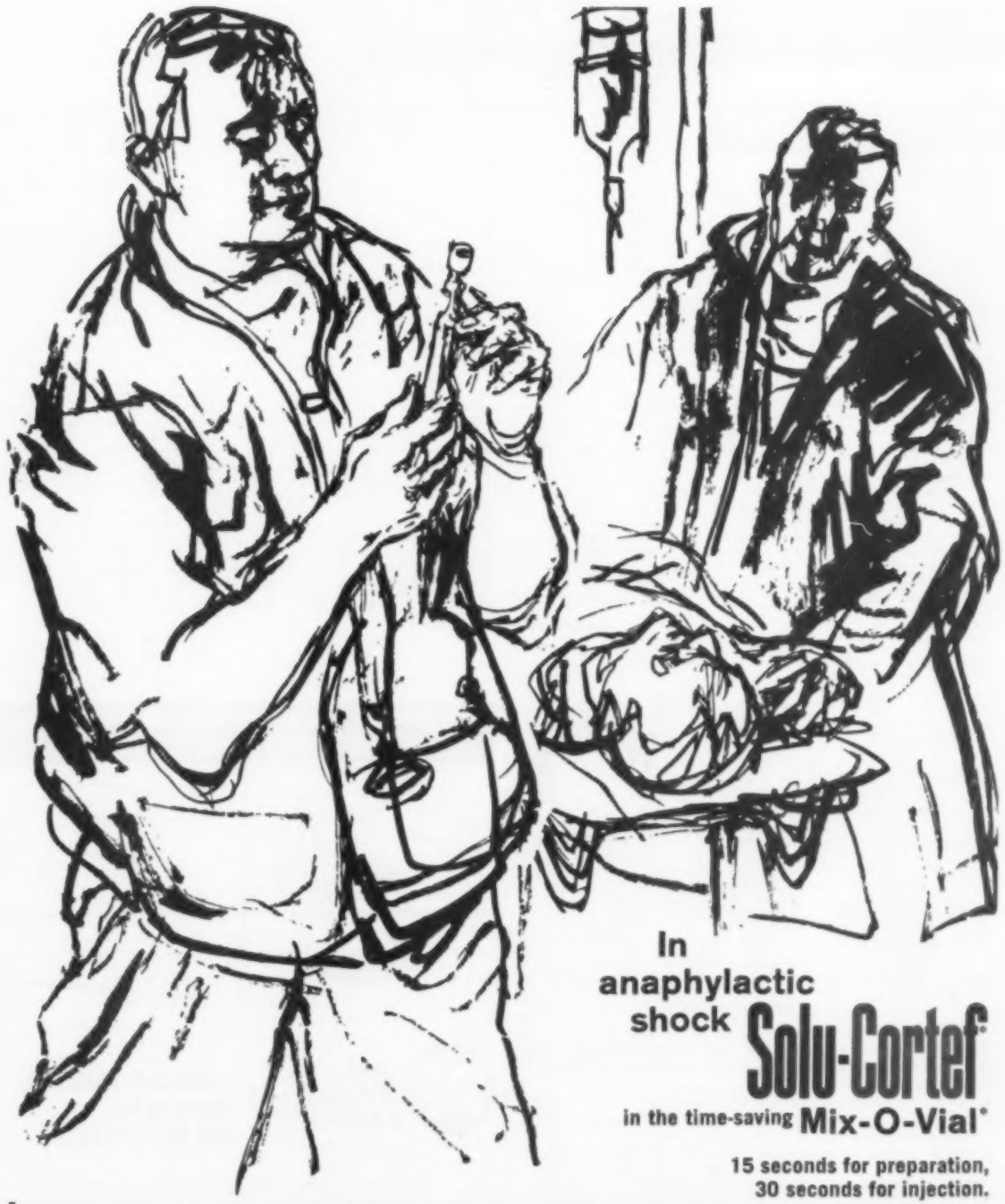
INSTRUCTOR—Clinical; medical and surgical nursing in integrated program; B.S. degree required; good personnel policies. Write Director of Nursing, Nathan Littauer Hospital School of Nursing, Gloversville, New York.

LIBRARIAN—Chief registered medical records; 111 bed accredited hospital in San Diego County; good salary; future advancement; fringe benefits. Write, Administrator, P.O. Box 158, La Mesa, California.

LIBRARIAN—Registration or graduation from approved school and one year experience; to head department in 516-bed cancer research hospital; a challenging opportunity offering a starting salary of $5,424, two and one-half weeks vacation the first year, 40 hour week, and other attractive working conditions and benefits. Reply Personnel Director, Roswell Park Memorial Institute, Buffalo 3, New York.

LIBRARIAN—Registered medical record; to take charge of record room; 360-bed, fully accredited hospital; salary open. Write Superintendent, Washington Hospital, Washington, Pennsylvania.

MISCELLANEOUS—Nursing arts instructor, Clinical instructor, Evening nursing service supervisor; good personnel policies in modern hospital. Apply Mrs. Aileen L. Carroll, Director of Nursing, Buffalo General Hospital, Buffalo 3, New York.



In anaphylactic shock Solu-Cortef® in the time-saving Mix-O-Vial®

15 seconds for preparation, 30 seconds for injection.

In acute anaphylactic emergencies, when the body reacts violently to drugs, antibiotics, or sera,[1] swift action can save a life that hangs by a thread. Injectable Solu-Cortef (hydrocortisone sodium succinate) rapidly combats shock and reverses hemodynamic collapse. Even when epinephrine and antihistaminics fail, and only a fair response can be obtained with ACTH, Solu-Cortef is usually dramatically effective.[2]

Administration and dosage: In acute anaphylactoid reactions, Solu-Cortef may be given in 100 mg. or 250 mg. doses, as indicated by the severity of the condition, and repeated at intervals of 1, 3, and 6 hours. Each Mix-O-Vial contains 100 mg. Cortef (as 133.7 mg. hydrocortisone sodium succinate) for intravenous or intramuscular use. If not injected immediately after mixing, refrigerate and use within 24 hours.

Supplied: As a 100 mg. and a 250 mg. Mix-O-Vial.

References: 1. Hull, E.: Kansas City M.J. 33:19 (March) 1957. 2. Grater, W. C.: Ann. Allergy 13:191 (March-April) 1956.

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POSITIONS OPEN

MISCELLANEOUS—Nurse Supervisors (2); General Staff Nurses (3); immediate opening; 84-bed hospital located in lake resort area only 65 miles from Chicago; 5 day, 40 hour week; starting salary commensurate with experience and qualifications range to $350.00 for supervisors; for general duty staff nurse to $325.00, with periodic increases; free meal daily, four uniforms laundered weekly, sick leave to 21 days, vacation time to 21 days. Apply to L. H. Furlong, Administrator, Fairview Hospital, La Porte, Indiana.

MISCELLANEOUS—Operating room supervisor, Anesthetist and Scrub nurse—Newly opened 100-bed hospital, air-conditioned, recovery room, central supply and other modern conveniences; near residential and business section of town. Apply Beaufort County Hospital, Washington, North Carolina.

MISCELLANEOUS—EDUCATIONAL DIRECTOR and SCIENCE INSTRUCTOR; provisionally accredited hospital school of nursing in central New York State, 30 students; B.S. Degree and experience required; Masters degree preferred. Reply MO 239, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

NURSING MISCELLANEOUS—Portland, Oregon, is a fine place to live; the University of Oregon Medical School Hospital is a fine place to work; Staff positions open in Medical, Surgical, Pediatric, O.R. and Isolation units; beginning salary $310.00 per month with six months' experience; liberal personnel policies; opportunities for taking course leading to baccalaureate or masters degree at nursing school on campus; reduced tuition rates for employees. Write for information to Director of Nursing, University of Oregon Medical School Hospital, Portland 1, Oregon.

NURSING MISCELLANEOUS—(a) Director Of Nursing; Administer and coordinate work of Nursing Service and School of Nursing; prefer masters degree in education or administration with successful experience. (b) Associate Director Of Nursing—in charge of School of Nursing; prefer masters degree in education but BS acceptable if accompanied by proven ability; JCAH accredited; non-sectarian hospital of 576-beds (including 125 non-acute beds) and NLN accredited, diploma school of 160 students; university affiliation for basic sciences; excellent salary, personnel policies and working conditions; furnished apartment at reasonable rent is available; City of 110,000 located in year round recreational area. Write Personnel Director, St. Luke's Hospital, Duluth 11, Minnesota.

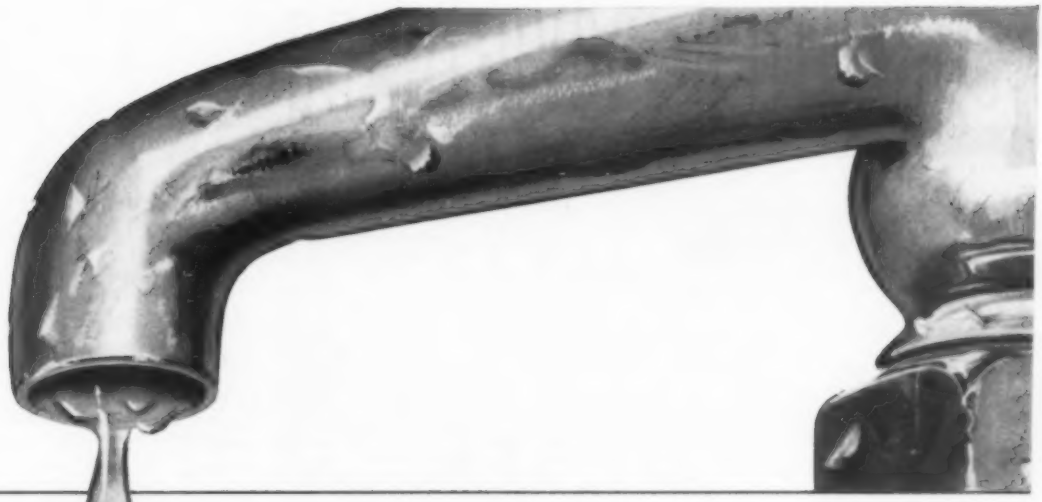
(Continued on page 230)

NURSING MISCELLANEOUS—Present 110-bed hospital organizing for the new 350-bed hospital, expanded opportunities immediately all nursing positions including supervisory; salary commensurate with experience and living conditions. Contact Administrator, All Saints Episcopal Hospital, Fort Worth 4, Texas.

NURSE—Head; new 30-bed hospital; active community near large city; salary open. Apply MO 235, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Registered staff; immediate openings; start $337 per month; differential pay, 5 day week; 11 paid holidays; sick leave, group insurance; good working conditions; large general hospital. Contact Personnel Director, 732 E. Main Street, Stockton 2, Cal.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 days week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5105.



How much of your budget drips down the drain?

More than you might think—unless you have Crane Dial-ese controls, designed to cut down water loss and water heating bills

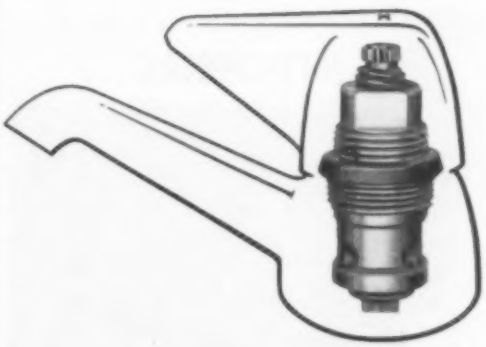
A drop of water a second, hour after hour, adds up to 2,300 gallons a year.

Multiply that by the number of faucets in your building, and you can see the incredible water waste that dripping can, and *does*, cause. And when it's *hot* water, there's a big fuel waste, too!

Crane Dial-ese controls are designed to stop this constant waste. For one thing, a Dial-ese control shuts off easier and all the way because it closes *with* the water pressure—not against it.

Dial-ese is designed to last longer, too. Stem threads are permanently lubricated at the factory—and sealed *inside* where water can't touch them. All working parts are in a single, simple cartridge that screws into the faucet. *Replacement is quick and easy*—just take out the old, put in the new.

All Crane fixtures (and *only* Crane fixtures) feature Dial-ese controls. Why not ask your architect for more details before you build or remodel?



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POSITIONS OPEN

NURSES — Registered; immediate openings; starting salary $280 month with opportunity for advancement; room, board and laundry; annual vacation, liberal sick leave, 40 hour week. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

NURSES—Staff, Psychiatric, and Public Health; $295 to $500, depending on qualifications; various locations, liberal fringe benefits, promotional opportunities. Apply Oregon State Civil Service Commission, Public Service Building, Salem, Oregon.

NURSES—Registered; for general duty; 37-bed hospital, beautiful resort area, northwest Wisconsin, 45 miles from St. Paul, Minnesota; liberal personnel policies. Write Mr. Thompson, Box 194, Taylors Falls, Minnesota.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

NURSES—Registered; operating room and staff; 35-bed general hospital; starting salary $340.00; differential for operating room and evening and night duty; excellent working conditions and personnel policies. Contact J. Milton Ramsour, Administrator, Memorial Hospital, Pecos, Texas.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSES—Registered; 170-bed general hospital, located in "The Fruitbowl of the Nation." ideal climate, convenient recreational facilities year round; starting base salary $300.00 per month, Apply Director of Nurses, Yakima Valley Memorial Hospital, Yakima, Washington.

NURSES—Registered; need dedicated Christian nurses for Esperanza General Hospital; 22-bed hospital; opportunities for witnessing for the Lord; salary $100 clear; 6 day week, 10 hour day. Apply Dr. H. A. McLean, Ceepeecee, Vancouver Island, British Columbia.

NURSES—General duty; for 55-bed hospital; salary $220 per month plus maintenance; annual increases up to 3 years; traveling expenses refunded on completion of 12 month service. Please apply Director of Nursing, The Lady Minto Hospital, Chapleau, Ontario.

PHYSICAL THERAPIST—Registered; 100-bed hospital; department well equipped. For information, apply G. N. Wilcox Memorial Hospital, Lihue, Kauai, T.H.

PLANT ENGINEER—Male or female; for medium size hospital located Upper Ohio Valley; send resume, stating required salary range to MO 236, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

RESIDENT PHYSICIAN—For general hospital specializing in geriatric patients; must be graduate of Class A school with approved internship; housekeeping apartments available on grounds; within easy commuting distance from Boston. Write or contact Superintendent, Cushing Hospital, Box 190, Farmingham, Massachusetts.

SUPERINTENDENT—Female; to reside at and manage Protestant Home and Infirmary for 80 aged women in upstate New York; salary and maintenance commensurate with ability. Write qualifications and experience to MO 237, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

SUPERINTENDENT—New 1500 bed mental hospital near Portland; qualified psychiatrist with five years' administrative experience; diplomates of the American Board of Psychiatry preferred; submit resumé and minimum acceptable salary to Oregon State Board of Control, Capitol Building, Salem, Oregon.

(Continued on page 232)

here's a

NURSE CALL SYSTEM THAT SAVES MONEY

Rhode Island Hospital
Providence, R.I.

Equipped with "Standard"
- Nurse Saver Calling System (8 floors)
- Room Occupancy Indicating System
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The STANDARD® NURSE SAVER® CALLING SYSTEM

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With the STANDARD Nurse Saver Calling System, one nurse easily handles up to 50 bedside call stations. Two-way voice communication saves countless miles of walking . . . improves service and provides reassurance to patients by permitting prompt contact.

A STANDARD system takes nurses out of the "errand girl" class . . . frees them to handle the specialized tasks for which they were trained.

Important savings in overhead . . . better use of personnel . . . improved patient relations—these are a few of the "extras" in service and savings that you get with a STANDARD Nurse Saver System.

And this is important, too: Standard's wide experience and specialization in the hospital field is your assurance that a Standard System will be engineered thoroughly and completely to fit the specific needs of each individual hospital. Write today for complete information on Standard

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POSITIONS OPEN

SUPERVISOR—Top operating room; "an excellent position for the right nurse" available immediately; 442-bed hospital; supervisory experience in a similar size or larger hospital required; five major and three minor operating room; over 9,000 procedures performed in 1957; department is well staffed; student nurse training under direction of fulltime instructor in surgery. Write or call the Director of Nursing Service, Saint Luke's Hospital, 601 East 19th Avenue, Denver 3, Colorado.

SUPERVISOR-INSTRUCTOR — Operating room; 209-bed general hospital; NLN fully accredited school of nursing; 96 students; 40 hour week; special clinical preparation in operating room supervision; salary open, liberal personnel policies. Apply Director of Nursing, Middlesex Memorial Hospital, Middletown, Connecticut.

SUPERVISOR—Administrative for obstetrical department; supervisor for evening shift; 365-bed general hospital; Bachelor's degree in Nursing Service Administration, but will consider others, and 5 years experience in supervision required; NLN accredited school of nursing; progressive personnel policies include 20 working days vacation; salary open; educational and cultural advantages of Chicago. Send resume of experience and training to Director of Nursing Service, St. Anne's Hospital, 4950 West Thomas St., Chicago 51, Ill.

TECHNICIAN—Laboratory; 236-bed general hospital 30 miles from New York City; interesting position with advancement in progressive hospital. Contact Personnel Office, Morristown Memorial Hospital, Morristown, New Jersey.

TECHNICIAN—Registered laboratory; Orleans County Memorial Hospital, Newport City, Vermont; 60-bed fully accredited general hospital; salary open. Write Dorothy N. Williams, R.N., Superintendent. Or telephone —76.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 N. MICHIGAN AVENUE, CHICAGO

ADMINISTRATORS— (a) Medical; to succeed director after long tenure; 300-bed hospital; east. (b) Assistant administrator; Master's in Hospital Administration, minimum two years' experience as assistant required; 325-bed general hospital; Pacific Coast. (c) Assistant administrator; Master's in Hospital Administration, several years' experience required; 600-bed general hospital; east; $7-$10,000. (d) Director, new general hospital, 135-beds; college town, New England; preferably one with master's, 5 years' experience; $10,000. (e) Administrator, new 40-bed community hospital currently under construction; university town, south. (f) Administrative assistant by medical administrator, 225-bed general hospital; building program will increase to 300; prefer young woman with Master's in Hospital Administration or Nursing; college town, midwest; $7200. MH9-1

ANESTHETISTS—(a) Small general hospital, southwest; salary or fee arrangement; $500. (b) Fee arrangement; hospital serving industrial area, south; approximately $700. MH9-2

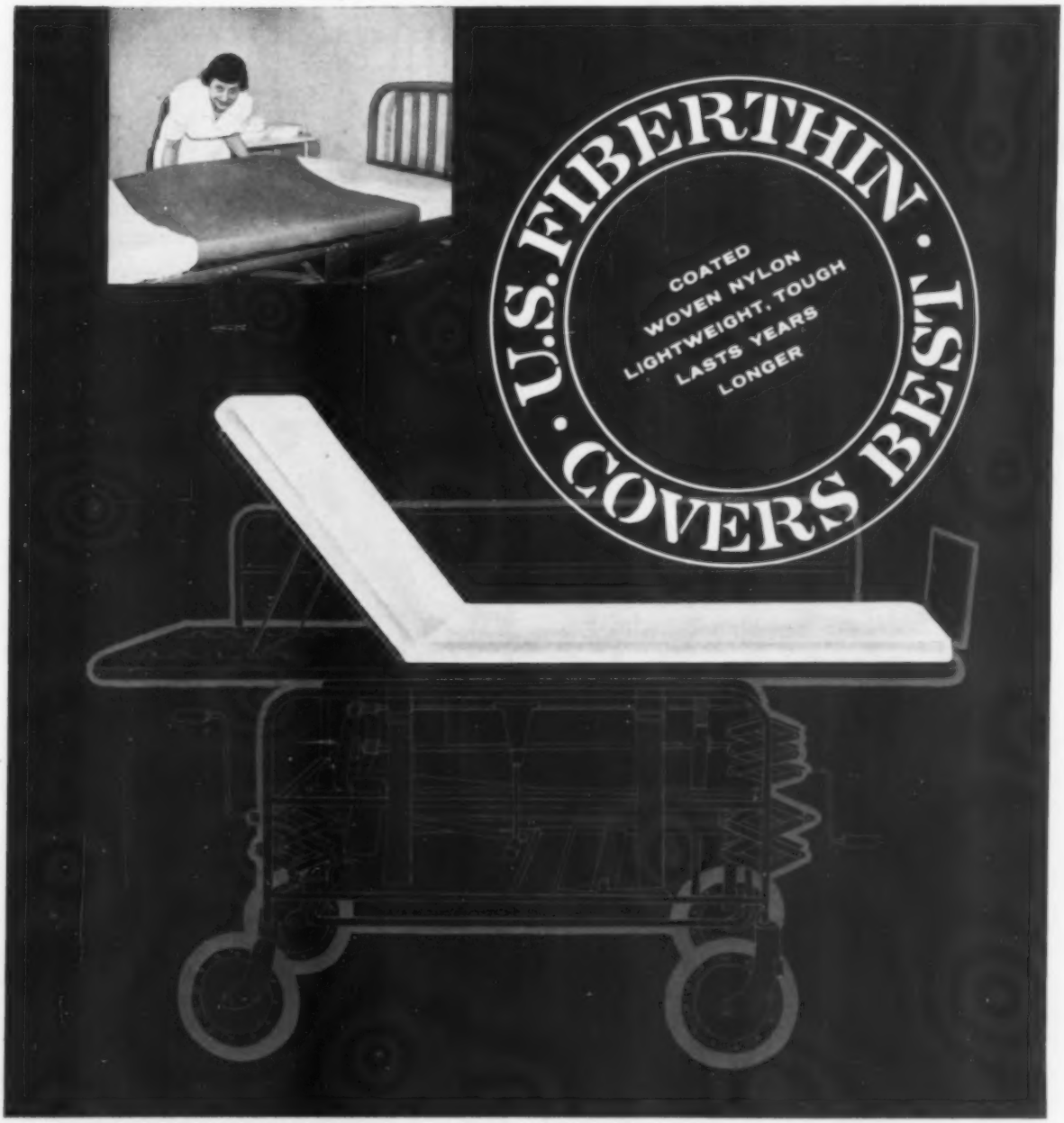
DIRECTORS OF NURSING—(a) Director, School of Nursing, new cooperative venture, collegiate affiliation, midwest; advanced degree and administrative experience required; to $10,000. (b) Director of nurses, 400-bed general hospital, famous resort city, Florida; to $7200. MH9-3

FACULTY POSTS—(a) Instructor, staff education; 225-bed hospital between New York City and Boston; to $5400. (b) Medical-surgical, science and pediatrics; 365-bed hospital, Florida; to $5200. MH9-4

PUBLIC HEALTH—(a) Instructor; Master's required; college of nursing; south; range $6800-$10,000. MH9-5

STUDENT HEALTH NURSE—(a) Exclusive girls' school; beautiful location, Pacific Northwest. MH9-6

(Continued on page 234)



U. S. FIBERTHIN®—WATERPROOF... LONG-WEARING... RESISTS HOSPITAL STAINS

For hospital beds and stretchers, U.S. Fiberthin has proved itself the best all-around protective sheeting on the market. Woven with ribbon-like threads of durable nylon, coated with either vinyl or neoprene, this modern covering fabric will not absorb the slightest bit of moisture. It protects completely against sheet and mattress damaging hospital stains. Nurses like U.S. Fiberthin because it is so extra light and easy to handle. Easy to launder, U.S. Fiberthin will withstand repeated autoclaving and outlasts other types of protective sheeting. Ask your supplier for U.S. Fiberthin—in rolls that can be cut to any size, or be made into fitted covers as shown above. For additional information, write United States Rubber, Mishawaka, Indiana.

United States Rubber
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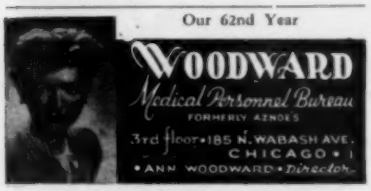
POSITIONS OPEN

MEDICAL BUREAU—Continued

STEWARDESSES—(a) East-south run; also Chicago to Northwest; important railroads. MH9-7

SUPERVISORS—(a) Orthopedic; 200-bed hospital, city of 30,000, east, near important industrial center; to $425. (b) Pediatrics; 30-bed department in 300-bed hospital, southwest; to $385. MH9-8

Our 62nd Year



Telephone: RAndolph 6-5682

ADMINISTRATORS—(a) Medical or non-medical; new university hospital, large size; important university center; very substantial; warm climate. (b) 375-bed, general, voluntary, fully approved; excellent nurses training school; $18-20,000; college town, 100,000; Central. (c) General, JCAH, 250-beds; $15-18,000; very desirable college town 35,000; southeast. (d) JCAH, 240-bed, voluntary general; one of finest towns 100,000; California;

WOODWARD—Continued

(e) Director of medical education; new post; voluntary, general, JCAH, 225-beds; adding 50-beds for clinic; training program in planning stage; large city, several new schools. (f) New 150-bed, general, under construction; appoint director soon; very attractive college town near Chicago. (g) 100-bed, modern, general hospital in plan-state; urgently requires director during planing and construction; resort area; South Atlantic.

ASSISTANT ADMINISTRATORS—(h) 600-bed, general, fully approved hospital; to $10,000; university city, east. (i) One of three assistants; large, fully-approved, general hospital; $6,000 plus family maintenance; large eastern city. (j) Direct 100-bed, fully approved pediatric hospital; report direct to executive director of hospital group, 4 specialized hospitals; large city.

ADMINISTRATIVE POSTS—(k) Administrative assistant; accounting training and experience; direct office personnel; large, fully approved hospital; $8,000; town 80,000, east. (1) Comptroller; group of 12 hospitals in midwest area; some travel; excellent potential; to $11,000. (m) Assistant purchasing agent; 1000, fully-approved university hospital; cultural and educational center, east.

EXECUTIVE HOUSEKEEPERS—(a) Capable reorganizing department, large hospital now expanding to over 500-beds; will consider candidate with administrative experience to advance later into such appointment; midwestern city 75,000. (b) Voluntary general

WOODWARD—Continued

hospital now expanding to 300-beds; southeastern city 30,000. (c) Full charge department, fully approved 300-bed general hospital; capital city 80,000; midwest. (d) Excellent opportunity for qualified executive to take over entire housekeeping function, plan new department in very large hospital now under construction; to $7500; eastern metropolitan area. (e) Organize, establish division, 300-bed hospital to be opened early 1959 as part of university medical center; to $5000; northwest.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—(a) 50-bed Illinois hospital. (b) 75-bed Ohio hospital. (c) R.N.; 40-bed mid-western hospital. (d) Assistant; 150-bed hospital; Michigan. (e) Purchasing agent; 400-bed Ohio hospital. (f) Administrative assistant; 200-bed Pennsylvania hospital.

COMPTROLLER—(a) 200-bed hospitals; Pennsylvania, Ohio, Virginia, Michigan; 145-bed hospital to $7500. (b) 400-bed mid-western hospital; $10,000.

DIRECTOR OF NURSING—(a) 240-bed Ohio hospital. (b) 300-bed eastern hospital. (c) Assistants charge nursing service. (d) Director, practical nursing schools.

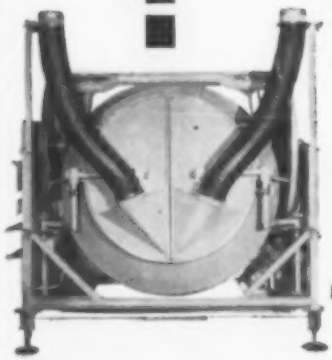
PERSONNEL DIRECTOR—340-bed hospital.

(Continued on page 236)

The Purkett Skyline of Satisfied Hospitals . . . .

Typical of the many hospitals where top operating efficiency in large flatwork and garment conditioning work will be found, due to Purkett's 72" Pre-Drying Conditioning Tumbler, are the above efficiently managed hospitals.

With the new 72-inch 25-ring PCT* laundry managers will get maximum performance in their conditioning operations with a new high of 4 lbs. moisture removal per minute. Although processing time is reduced, the quality of work is improved.



Two 8-inch vents eliminate the heat and lint output menace.

Large squirrel type blower supplies 2300 cfm, cutting cycling time.

The heat coil is the heart of the PCT*. The 25-ring unit gives 108% more heating surface than the 12-ring unit.

Write for literature . . . or ask to have a Purkett engineer discuss your conditioning problems with you . . . no obligation, of course.

Naturally it's a PURKETT

*PRE-DRYING CONDITIONING TUMBLER

Purkett equipment is sold by ALL Major Laundry Machinery Manufacturers and by

PURKETT MANUFACTURING COMPANY
Joplin, Missouri
DEPENDABLE PRE-DRYING CONDITIONING TUMBLERS

For additional information, use postcard on page 270.

classified advertising

POSITIONS OPEN

INTERSTATE—Continued

EXECUTIVE HOUSEKEEPER—(a) 350-bed hospital, New England. (b) 200-bed modern hospital; east. (c) 340-bed hospital; large mid-western city. (d) 175-bed Ohio hospital.

CHIEF PHARMACIST—(a) 340-bed hospital; west. (b) Staff pharmacists; east, mid-west.

X-RAY TECHNICIAN—(a) Teaching duties; 300-bed hospital; Ohio; $400. (b) Laboratory technicians; $350-$450.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

EXECUTIVE PERSONNEL—(a) Personnel director; California; 125-bed hospital. (H-2303). (b) Controller-Business manager; middle west, near Chicago; 250-bed hospital; good accounting background; $7800.00 (H-3008). (c) Personnel director; southwest; 500-bed teaching hospital. (H-2195). (d) Purchasing agent; east; 500-bed hospital. (H-2229). (e) Accountant; travel for hospital management company checking member hospitals; east. (H-2174).

SHAY—Continued

DIETITIANS—(a) Administrative; west. 275-bed hospital; complete charge of dietary department; expansion program will require complete reorganization of food service program. (MH-2214). (b) Chief; east; 175-bed hospital; well qualified assistants; $6000. (MH-1305). (c) Chief; middle-west; 200-bed hospital; expansion program in near future and there will be a completely new and modern dietary department; to $7500. (MH-2046). (d) Chief; south; new 300-bed hospital; set up and supervise food service; 40 in department; $6000. (MH-1672). (e) East; supervise 40 to 50 persons engaged in procuring, producing, and distributing food to patient food service areas from central kitchen; 600-bed teaching hospital; $5040. (MH-2077). (f) Administrative; Pacific Northwest; 300-bed teaching and research hospital dietary department, new and modern. $5700. (MH-2240).

CLINICAL PSYCHOLOGISTS—(a) South; medical agency caring for exceptional children; graduate work and experience equivalent to a doctorate degree; $8000. (MH-1968). (b) Psychology consultant in commissioners office of State Department of Mental Health; require PhD; $7000 minimum. (MH-1955). (c) State hospital; west; duties: psychological evaluation and phychotherapy, individual and group; $8300. (MH-2177). (d) East; 700-bed hospital; psychological services and testing in active state mental hospital program; prefer PhD; $9454. (MH-2232).

(Continued on page 238)

SHAY—Continued

NURSE ANESTHETISTS—(a) Middle west; 140-bed hospital; $600. (MH-2008). (b) South; 125-bed hospital; 2 full-time and 3 part time anesthetists; $500 plus maintenance. (MH-2252). (c) Southwest; 120-bed general hospital; 3 in department; $605. (MH-2307).

MEDICAL EMPLOYMENT SERVICE
59 East Madison Chicago 2, Ill.
ANdover 3-5663-64
Alfred E. Riley, R.N., MSHA Director

ADMINISTRATORS—(a) 500-bed hospital; northwest state; salary $7,500. (b) 600-bed hospital; Idaho; salary $7,200. (c) 50-bed hospital; Texas; salary $8,500. (d) 1000-bed hospital; Pennsylvania; salary $7,770. (e) New 50-bed hospital; Wisconsin; salary $7,500.

ANESTHETISTS—(a) Male; Chicago; salary $600. (b) Male or female; Illinois; salary $600. (c) 50-bed new hospital; salary open. (d) Combination administrator & anesthetist; male; salary $8,500.

DIRECTORS OF NURSES—(a) 500-bed Sisters hospital; charge of education and administration; sister will work under director of nurses; salary open; Illinois. (b) 350-bed Sisters hospital; salary $600; Ohio. (c) 300-bed teaching hospital; south; salary $600. (d) Director of nurses; for large psychiatric hospital; salary $800.

Use quality floor waxes containing Du Pont's anti-slip ingredient

LUDOX®

COLLOIDAL SILICA

DU PONT

REG. U. S. PAT. OFF.

BETTER THINGS FOR BETTER LIVING
. . . THROUGH CHEMISTRY

You benefit two ways with floor wax containing "Ludox". First, there's the skid resistance "Ludox" adds. Tiny, transparent spheres of "Ludox" exert a snubbing action with every footstep . . . give sure-footed traction. Second, you get the lasting beauty only a fine wax can give your floors . . . and it's easy to *keep* floors beautiful, because scratches and scuffs can be buffed out, without rewaxing.

Floor waxes containing "Ludox", Du Pont's anti-slip ingredient, give your floors the appearance you want, plus added safety underfoot. Mail coupon below for more information and a list of suppliers for products containing "Ludox". E. I. du Pont de Nemours & Co. (Inc.), Grasselli Chemicals Department, Room N-2533, Wilmington 98, Delaware.

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DOUBLE-ACTION RUG AND UPHOLSTERY SHAMPOOS—A NEW USE FOR LUDOX®

New shampoos containing "Ludox" *clean and treat* rugs against resoiling in just one application. "Ludox" fills microscopic fiber crevices . . . protects surface so dust and dry dirt don't cling. Dirt stays on surface for easy removal.

I'm also interested in:
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Grasselli Chemicals Department, Room N-2533MH
Wilmington 98, Delaware

Please send me the free booklet describing the advantages of using floor wax containing "Ludox."

Name_____

Firm_____ Title_____

Address_____

City_____ State_____

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classified advertising

POSITIONS OPEN

MEDICAL EMPLOYMENT—Continued

PHARMACISTS—(a) MS. Degree, Teaching; Colorado; salary $7,500; University Hospital. (b) 200-bed hospital; Ohio; salary $600. (c) 300-bed hospital; southwest; salary open.

PURCHASING AGENTS—(a) Combination purchasing agent and pharmacist; Chicago; salary open. (b) 400-bed hospital; Delaware; salary $500. (c) 300-bed hospital; New York City; salary open. (d) 100-bed hospital; Connecticut; salary open.

DIETITIANS—(a) MS Degree, Teaching and Administration; salary $600. (b) 300-beds; Michigan; salary $500. (c) 200-bed hospital; west; salary $450. (d) Administrator; 60-bed new hospital; Wisconsin; salary $400.

OCCUPATIONAL THERAPISTS—(a) Illinois; salary to $550. (b) 100-bed hospital; New York; salary $500. (c) 200-bed Sisters hospital; chief of department; salary open; Wisconsin.

PHYSICAL THERAPISTS—(a) Chief; salary $550. (b) 300-bed hospital; northwest; salary $450. (c) Many other areas ranging from $450 to $500.

MEDICAL EMPLOYMENT—Continued

EXECUTIVE HOUSEKEEPERS—(a) Male; New York City; salary $7,500. (b) 300-bed hospital; Ohio; salary $6,000. (c) Illinois; 100-bed hospital; salary $5400.

BUILDING SUPERINTENDENTS—(a) New 150-bed hospital; engineering license required; salary open. (b) 500-bed hospital; license reg; salary open.

LABORATORY TECHNICIAN—(a) ASCP; 100-bed hospital; salary $500. (b) Chief; male; ASCP; salary $600. Many other excellent openings.

X-RAY TECHNICIANS—(a) Chief; teaching school; salary $500. (b) 50-bed hospital; $350. (c) 100-bed hospital; salary $400.

ALLIED OFFICES BUSINESS & MEDICAL PERSONNEL
1520 Westlake at 4th MA 4-4793
Metropolitan Bldg.
Seattle 1, Wash.

Northwest—(a) Physician associate; established clinic, fine doctors, obstetrics & gynecology—board eligible. (b) Registered nurse; operating room, new hospital for boardmen; open. (c) Dietitian therapeutics; open. (d) Microbiology serology; recent graduate or experience; excellent. (e) Registered nurse; 3: 11 p.m. general duty; $350.

(Continued on page 240)

PLACEMENT BUREAUS

MARY A. JOHNSON ASSOCIATES
11 West 42 Street New York 36, N.Y.

Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven methods shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee
Agency

For additional information, use postcard on page 279.

classified advertising

PLACEMENT BUREAUS

DOROTHEA BOWLBY ASSOCIATES
8 South Michigan Avenue Chicago 3, Ill.
Suite 1420—ANdover 3-5293
Dorothea Bowlby, Director

A Specialized Employment Service for Medical and Hospital Personnel. (Men and Women.) For Administrators, Personnel Directors, Business Managers, Dietitians, Physicians, Directors of Nurses, Therapists, Pharmacists, Medical Record Librarians, Anesthetists, Public Relations Directors, Housekeepers, Bacteriologists, Biochemists, Medical Technologists, X-Ray Technicians, Food Service Managers. All inquiries from applicants are kept strictly confidential.

INDIANA MEDICAL BUREAU
212 Bankers Trust Bldg.
Indianapolis 4, Indiana

Opportunities in most areas for Administrators, Medical Directors, Anethesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

FOR SALE

NURSING AND MEDICAL BOOKS
We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.
HARRY D. WELLS
400 East 59th Street, New York City

FOR RENT

Ex-Hospital Building available FOR RENT; to be converted into NURSING HOME for approximately 40 patients; Southern Illinois Community; only experienced operators should submit offers. Reply P. O. Drawer 100, Rosiclare, Illinois.

SCHOOLS—SPECIAL INSTRUCTION

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all technique in inhalation, intravenous, and rectal anesthesia. Unlimited opportunities for endotracheal intubation and open chest anesthesia. Stipend provided. For information write School for Nurse Anesthetists, University Hospital, Ann Arbor, Michigan.

---

now . . . for the first time . . .
two new oxygen-tent units that are *easy to wash!*-

McKesson AQUALORS

Just remove door on top. Then wash the coils with hose or large volume of water!

Don't worry! Large-diameter drains mean quick removal of wash-water.

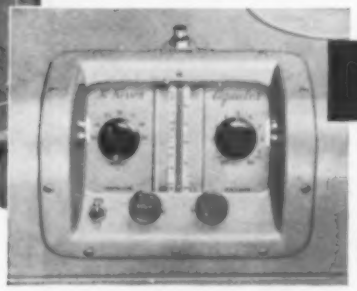
A great convenience to service personnel.

Only McKesson Aqualors have this feature!

100% HUMIDITY MAINTAINED BY THIS MODEL 1150!

Nebulizer is located in bellows-tube connection. Easily removed by service personnel.

STANDARD AQUALOR (Model 1155) is identical to Model 1150, except for High-Humidity feature.



Lighted Control Panel

note oxygen flowmeter (center), temperature and ventilation controls (left and right), oxygen controls (bottom).

McKesson
AQUALOR
OXYGEN TENTS

for full information

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McKESSON APPLIANCE COMPANY • TOLEDO 10, OHIO

announcing... a significant improvement in the most advanced ACTH!

ELECTROLYTIC CORTROPHIN®-ZINC

(Corticotropin-*Alpha* Zinc Hydroxide) 'Organon'

A unique electrolytic process of manufacture* has produced a fine, easily resuspended aqueous suspension of CORTROPHIN-ZINC possessing these therapeutic advantages:

****VIRTUALLY PAINLESS**
New Cortrophin-Zinc has received unsurpassed acceptance in hundreds of clinical patients.

****RAPID ACTION**
New Cortrophin-Zinc stimulates peak adrenal output within 2 hours.

****HIGHEST PURITY**
New Cortrophin-Zinc contains the purest commercially available ACTH, as shown in comparative studies to be published.

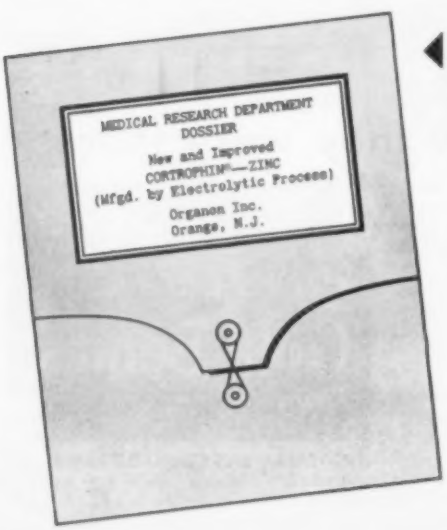
****LONG ACTION**
New Cortrophin-Zinc provides therapeutic ACTH activity for several days (40 Units).

****INCREASED ECONOMY**
New Cortrophin-Zinc reduces the amount of ACTH and the number of injections required in a course of ACTH therapy.

AVAILABLE:
5-cc vials, each cc containing 40 U.S.P. Units of corticotropin adsorbed on 100% alpha zinc hydroxide for prolonged activity (1.0 mg. of zinc/cc).

HOSPITAL INDICATIONS:

Allergic Rhinitis	Lupus Erythematosus
Angioneurotic Edema	Ophthalmic Diseases
Anogenital Pruritus	Pemphigus
Arthritis	Periarteritis Nodosa
Asthma	Poison Ivy, Oak & Sumac
Bursitis	Serum Sickness
Contact & Drug Dermatitis	Surgery
Gout	Tenosynovitis
Hay Fever	Ulcerative Colitis
Insect Stings	Urticaria



*For clinical and experimental evidence on new and improved CORTROPHIN-ZINC sign and return the coupon

Organon INC., ORANGE, N. J.

*Electrolytic Process Patent Pending

Organon INC., ORANGE, NEW JERSEY

Gentlemen:

Please send me your dossier with clinical and experimental evidence on new and improved Cortrophin-Zinc.

Name_____

Name of Hospital_____

Address_____

City_____ Zone____ State_____

For additional information, use postcard on page 279.

Only the patient in 426 knew they were there

That's how well this Gold Bond® Travacoustic Ceiling protects your patients and staff from disturbing hallway noises—even during visiting hours! Travacoustic absorbs up to 85% of noise striking it.

Travacoustic gives you a beautiful ceiling too. It's attractively fissured, and has a clean, white surface for high light reflectance. Travacoustic is incombustible, can be easily vacuum-cleaned or repainted.

For more information, please write Dept. MH-98, National Gypsum Company, Buffalo 2, N. Y.

Gold Bond
BUILDING PRODUCTS
NATIONAL GYPSUM COMPANY

Edited by BESSIE COVERT

WHAT'S NEW

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form on page 279. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Ritter Twin-Track Light
First Unit in New Surgical Line

The first unit introduced in the new Ritter line designed especially for use in the surgery is the Twin-Track Major Surgical

Light, Model TS-25. Designed for maximum cleanliness with minimum effort, and to contribute to aseptic technic through elimination of dust-collecting problems, the new light has long semi-enclosed tracks mounted on the ceiling outside of the immediate sterile area, a single arm reflector support which totally encloses all wiring and remote control elements, and dual heat control glass mounted within the 25-inch elliptical reflectors.

Other features of the new Twin-Track Light include sterilizing facilities for the focusing handle which permit the surgeon to adjust and focus the light pattern and size from six to a full 10-inch field, a wall-mounted control for adjustment of illumination intensities from 2500 to 10,000 foot-candles, and superior illumination, heat control, shadow reduction and focal depth of the surgical beams with color correction. The Major Twin is designed for reducing shadows to the absolute minimum and is especially effective in operative work at adjacent anatomical sites within one cavity or at separate incisions operated simultaneously. **Ritter Co., Inc., Rochester 3, N. Y.**

For more details circle #367 on mailing card.

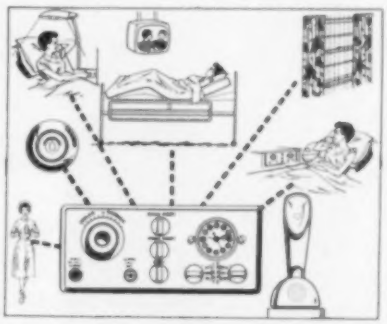
Glasco Product Packages
All Identifiable by Color

A new family of packages which are all quickly identifiable on storeroom or department shelves by color is now used for Glasco Products. The packages are printed in bright yellow and green and all of the boxes have a panel for special hospital imprints if desired. Included in the new packages are Tongue Blades, Applicator Sticks, Cotton Tipped Applicators and Microscope Blades. **Glasco Products Co., 111 N. Canal St., Chicago 6.**

For more details circle #368 on mailing card.

Nursing Hours Saved
With Bedside Control Center

The saving of countless hours of nursing time and effort, plus the very important public relations benefit of a contented patient, can be accomplished through installation of the automatic bedside control center developed by Minneapolis-Honeywell. The unit is designed to free the nurse from routine bedside tasks and thus help reduce the increasing costs of patient care. The patient who is past the critical stage can, by merely pushing buttons or twisting knobs, accomplish all of the comfort-type services himself without waiting for the busy nurse to come into the room. The completely in-



tegrated system is mounted in the bedside table which is easily mobile on its ball-bearing casters so that the patient can bring it into the most comfortable position for operating, either from the bed or from a chair when he is ambulatory. Provision is made for locking out the bed control when oxygen is being used.

Each control center has a sweep-second-hand clock and is set up to activate any number of services available in the hospital. It is used to raise and lower motorized beds, to adjust head and knee rests, to open and close motorized draperies on windows, to turn bedside lights on or off, to regulate the room temperature, to operate radio and television, including closed circuit TV for room-to-lobby visits with children or others not permitted in the patient's room, to call the nurse, and to operate the two-way intercom between the patient and the nursing station. Operating as a part of the center is the Ericofon with hand set and dial in one piece, permitting the patient to dial from a prone position. A light behind the control panel makes all instructions readable at night through transparent insets. Each unit is custom designed for the facilities available and the cost is relatively low. **Minneapolis-Honeywell Regulator Co., 2753 Fourth Ave. S., Minneapolis 8, Minn.**

For more details circle #369 on mailing card.

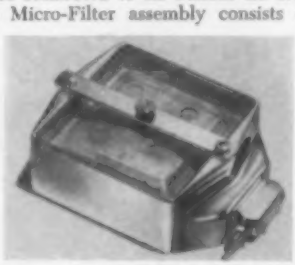
Safety Bed Rails
Store Below Mattress Level

The Universal Safety Side Bed Rails can be permanently attached to any hospital bed, available whenever needed, yet completely out of the way when not in use. The safety side is raised with one simple, one-hand motion, locking automatically in place. When not needed, or during patient care, the lock, which is out of reach of the patient, is easily released by nurse or attendant and the side folds into storage toward either the head or the foot of the bed. Cross extension turn-buckles connect the rails at both ends under the bed, for maximum strength and rigidity. **Hausted Mfg. Co., Medina, Ohio.**

For more details circle #370 on mailing card.

Infant Incubator
Filters Air-Borne Pathogens

Designed to help minimize the danger of air-borne infections in the premature nursery, a new Micro-Filter is now available for use on the Isolette infant incubator. The simple, efficient air filter provides complete isolation within the Isolette even when it is not connected to an outside air source. The Micro-Filter assembly consists of a



polished, cast aluminum filter body, clear plastic cover, oxygen input nipple, all necessary fasteners for installation on any Isolette incubator and a dozen fibrous Micro-Filter pads. **Air-Shields, Inc., Hatboro, Pa.**

For more details circle #371 on mailing card.

(Continued on page 246)

Folding Back Rest Folds Flat for Storage

Maximum comfort and support with minimum storage space are features of the new Pedangle Folding Back Rest introduced by Zimmer. Strap webbing is used to fasten the back rest securely to any hospital bed. The unit is made of aluminum tubing and canvas, is light in weight, folds flat for storage and provides support when needed after surgery or for geriatric and heart patients. **Zimmer Mfg. Co., Warsaw, Ind.**

For more details circle #372 on mailing card.

One-Step Disinfectant-Detergent Available in Tergisyl

Labor costs on hospital floor cleaning can be considerably reduced when done by the mop and pail or the machine scrubbing method when Tergisyl is used. The one-step disinfectant-detergent is the result of three years of research. It offers comprehensive bacteriocidal, fungicidal, tuberculoidal efficiency with detergency sufficient to clean heavy soil, and is said to have no effect on conductivity of operating room floors. Tergisyl is offered in concentrated solutions in one, five, fifteen and fifty gallon containers. **Professional Div., Lehn & Fink Products Corp., 445 Park Ave., New York 22.**

For more details circle #373 on mailing card.

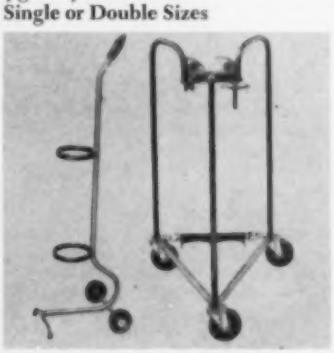
Surgical Skin Drape Isolates Wound from Skin

Isolation of the surgical wound from the patient's own skin, considered to be a significant source of infection, is now possible with the new surgical skin drape, Vi-Drape, and Vi-Hesive Surgical Adherant. The sterile plastic drape forms a bacterial barrier to prevent entrance of environmental bacteria into the wound. Vi-Drape is a vinyl film, each drape 42 by 24 inches in size, packaged in roll form ready for sterilization. It is interleafed with wet-strength paper to prevent film-on-film contact during sterilization.

In the use of the new materials, the skin is scrubbed and prepared in the usual manner, dried, and Vi-Hesive sprayed over the entire area. Vi-Drape film is then applied, smoothed and molded to the skin, providing a complete sterile field. Skin towels and towel clamps are completely eliminated and the film is impermeable to bacteria and fluids. The surgical incision is made through the Vi-Drape film so that no skin is exposed in the surgical area as a possible source of infection. In closing the wound the Vi-Drape film may be peeled from the margin of the wound or the skin may be sutured through the film. **Aeroplast Corp., 420 Dellrose Ave., Dayton 3, Ohio.**

For more details circle #374 on mailing card.

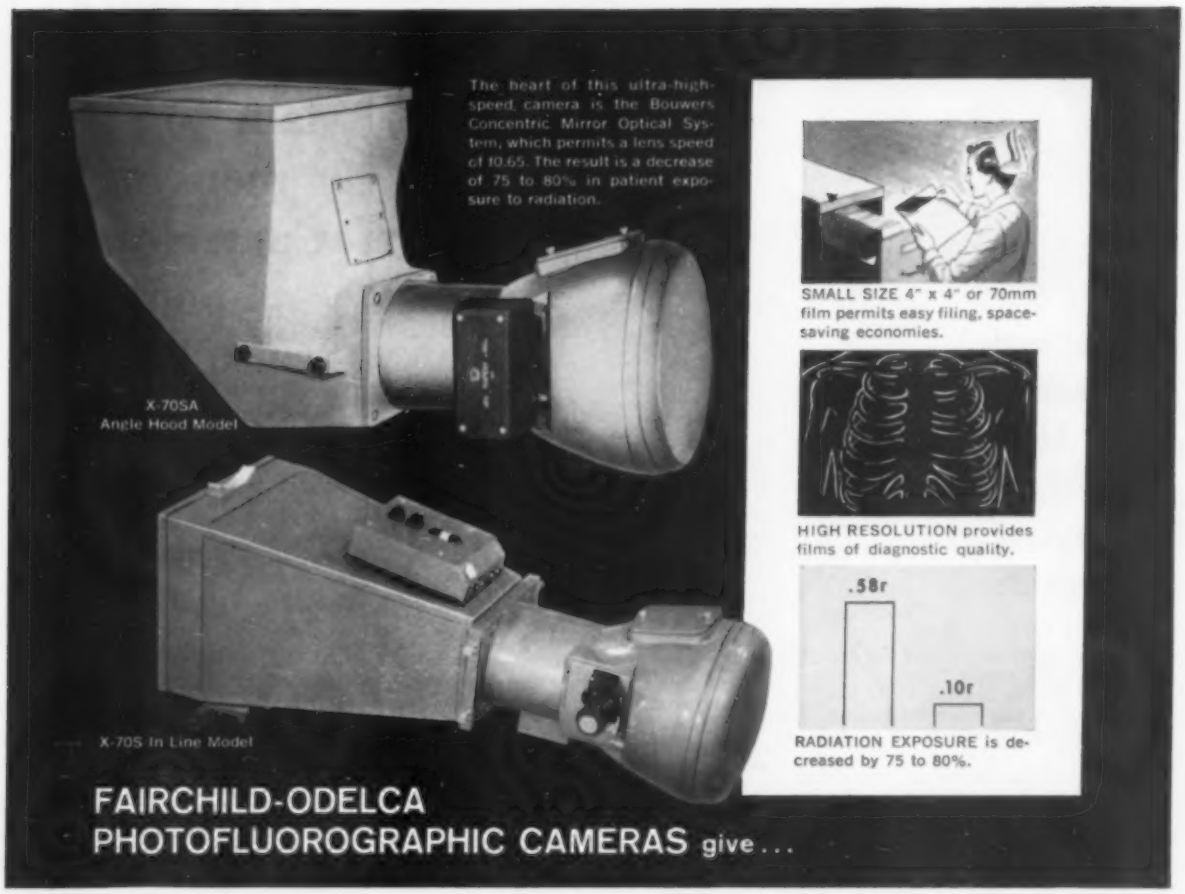
Oxygen Cylinder Carts in Single or Double Sizes



Two small new oxygen cylinder carrying units are introduced by Ohio Chemical. The single cylinder truck is highly mobile, fashioned after a golf cart. Two rubber-cushioned retaining rings hold an "E" cylinder snugly and a hook for hanging mask assemblies is furnished. Plastic cylinder stabilizers on the double cylinder carrying cart keep "E" cylinders secure. The yokes are pin-indexed for oxygen and two brackets are provided for hanging accessories, such as mask and humidifier. Both units are sturdily constructed of steel with a baked on enamel finish of silver-luster green and have conductive rubber tires for quiet, smooth operation. **Ohio Chemical & Surgical Equipment Co., 1400 E. Washington Ave., Madison 10, Wis.**

For more details circle #375 on mailing card.

(Continued on page 248)



Clear, sharp negatives of diagnostic quality with 80% less patient exposure to radiation!

The Fairchild-Odelca Camera provides photofluorographic negatives with 400% better resolution than standard refractive lens cameras. Yet, the camera's high lens speed—more than four times that of refractive lens cameras—reduces patient exposure to X-rays by 70 to 80% . . . stops much voluntary and involuntary motion.

A recently published report by the executive committee of a national association concerned with tuberculosis prevention states: "Whenever the purchase of a new photofluorographic unit is contemplated, the mirror optical system camera is to be preferred over the ordinary lens system." The report further states that this preference is due to reduction in radiation and superiority of results.

Two Camera Sizes Available

The Fairchild Ultra Speed 4 x 4 Camera gives a negative of clear, sharp diagnostic quality, which can be viewed conveniently without magnification and filed with the patient's record. With a Standard Speed Casette and a Standard Safety Monitor, this camera is recommended for hospital admission X-rays. The magazine holds up to 100 sheets of 4" x 4" film, of which one or several may be removed for development at any time after exposure.

The Fairchild 70 mm Camera, equipped with a 100-foot roll film casette, is ideal for routine chest X-rays in hospitals or mass chest surveys in tuberculosis prevention stations. A 40-exposure hand-operated casette is available for routine hospital admissions work; a 40-exposure motor-operated casette permits serial studies at speeds up to six exposures per second.

For complete details on Fairchild-Odelca Photofluorographic Cameras, consult your regular X-ray equipment supplier, or write direct to Faichild Camera and Instrument Corporation, Industrial Camera Division, 5 Aerial Way, Syosset, New York, Dept. **52.**

FAIRCHILD
X-RAY CAMERAS AND ACCESSORIES

Positive Retention of Pressures Assured With Pneumatic Tourniquet

The Richards Pneumatic Tourniquet has a new cuff containing the inflation system which can be easily applied or removed in seconds. It fastens with a single wide nylon strap with an airplane belt type lock. The

improved cuff construction prevents rolling or shifting of position of the tourniquet. It lays flat against arm or leg when inflated and pressure is applied evenly over a large area.

With the system in the cuff, inflation and deflation may be effected without disturbing the operator or the sterile drapes during surgery. The improved gauge has white numerals on black background for easy reading, with average arm and leg pressures indicated. The Pneumatic Tourniquet incorporates all the advantages of the Campbell-Boyd tourniquet, plus the improvements. **Richards Mfg. Co., 756 Madison Ave., Memphis, Tenn.**

For more details circle #376 on mailing card.

Microfilm Reader-Printer Makes Enlargements in 10 Seconds

Immediate copies of microfilmed material can now be made with the new Thermo-Fax brand microfilm reader-printer. The microfilm is projected on the viewing screen in the usual manner for reading. When a copy of any material is required, a button is pressed and in less than ten seconds the

copy is available. A special white paper 8½ by 11 inches in size is used for the enlarged copies which are made by a one-step system.

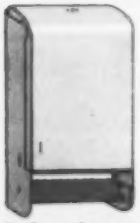
The new reader-printer operates on standard current and can be placed on any desk or table. It measures 17 by 19 inches, 25 inches high, and comes in a two-tone green metal cabinet. Operation consists of turning a selector to move the microfilm frames for reading, and pushing a button to make a copy. **Minnesota Mining & Mfg. Co., 900 Bush Ave., St. Paul 6, Minn.**

For more details circle #377 on mailing card.

(Continued on page 250)

SLOW LEAK IN YOUR TOWEL BUDGET?

HALT IT WITH THIS NEW DELAYED-FEED DISPENSER



Fresh towel appears only when special fin, exclusive with Nibroc, is pressed.

Money dribbling away because paper towels are being wasted. Stop such waste and slash towel consumption *up to 20%* with the exclusive *new Nibroc® delayed-feed economy towel dispenser*—for use with any white or natural shade Nibroc multifold towel. No waste butt rolls—no time device to get out of order. Trouble-free waste-control mechanism discourages "two-or-more-pulls"—users enjoy Nibroc towels that are unexcelled in absorbency, strength, softness. Mail the coupon today for case histories showing substantial dollar savings.

Brown Company
150 Causeway St., Boston 14, Mass.

Please send me case-history proofs of 20% savings with new NIBROC DELAYED-FEED ECONOMY TOWEL DISPENSER.

NAME _____

COMPANY _____

STREET _____

CITY _____ STATE _____

BROWN COMPANY

General Sales Offices: 150 Causeway St., Boston 14, Mass.
Mills: Berlin and Gorham, New Hampshire

NIBROC TOWELS • NIBROC TISSUE • NIBROC CABINETS • NIBROC WIPERS

For additional information, use postcard on page 279.

High-Speed Kodak Films Reduce Exposure Time

Reduction of radiographic exposure for diagnostic and cine-fluorographic studies is possible with use of two new Kodak films. The new Kodak Medical No-Screen X-ray Film is substantially faster than previous x-ray films, reducing exposure time up to one-third. Where required, exposure time may be kept the same as previously, but development time may be reduced, speeding diagnosis in emergency or during surgery.

The second new high-speed film is for 35mm cine-fluorographic studies. Kodak Cineflure Film is said to be twice as fast as previous films, permitting the alternative of obtaining the same amount of footage with reduced exposure time in cine-fluorographic studies, or exposing twice as much movie footage without increased patient exposure to radiology. The new film is supplied in perforated 200-foot lengths in 35-mm width only. **Eastman Kodak Co., Rochester 4, N. Y.**

For more details circle #378 on mailing card.

Portable Generator Set for Continuous or Standby Power

The new G-226 Generator Set is a portable, lightweight unit developing 35,000 watts for either continuous or standby power. The unit is complete as a package with all controls and accessories required for immediate use. It can be used indoors or out as the switchboard and instrument panel are protected against weather, dirt and tampering by a completely enclosed cabinet with a glass door that can be locked. The unit operates on gas or gasoline. **Allis-Chalmers Mfg. Co., Engine-Material Handling Div., Milwaukee 1, Wis.**

For more details circle #379 on mailing card.

Lowerator Dispensers In Meals-on-Wheels System

The Model TA-100 mobile cold tray assembly table of the Meals-on-Wheels Food Service System now incorporates two AMF Lowerator Dispensers for increased ease of handling butter plates and saucers when

loading trays. Stainless steel coil-spring mechanisms on the Lowerators automatically position saucers or plates at the proper serving level, and dishes are held in alignment by three stainless steel posts. The stainless steel assembly model handles trays, glasses, butter plates, saucers, silverware, packaged items, condiments, tray covers, napkins and standard cold items for 100 patient trays. Addition of the two Lowerator Dispensers increases efficiency and eliminates stacking dishes. **Meals-on-Wheels System, 5001 E. 59th St., Kansas City 30, Mo.**

For more details circle #380 on mailing card.

Design of Perineal Lamp Prevents Burns

The Heal-Lite Perineal Lamp is designed for obstetric and post-operative conditions calling for application of heat, including the drying of casts. Made of lightweight, sturdy aluminum alloy, the Heal-Lite Lamp has an outer shell surrounding the inner core which holds the radiant lamp housing.

The air space between the two shells acts as an insulator and prevents patient contact with the lamp, eliminating the danger of burning or shock. The lamp is kept upright by two wide foundation legs. The lamp has completely open construction for easy cleaning and it can be sterilized by submersion. **Heal-Lite, 136 Tompkins St., Cortland, N. Y.**

For more details circle #381 on mailing card.

(Continued on page 252)

WHITER LAUNDRY
LONGER FABRIC LIFE
UP TO 75% LESS SOAP

with the ELGIN WATER SOFTENER

OUTSTANDING FEATURES

- Up to 44% more soft water
- Prevents costly zeolite loss
- Zeolites that give up to 10 times greater capacity
- Fully-automatic, semi-automatic, or manual operation

A REAL MONEY SAVER FOR INSTITUTIONAL, COMMERCIAL, AND SELF-SERVICE LAUNDRIES

WHEN it comes to downright savings and benefits, there's nothing like sparkling clear soft water from an Elgin Water Softener. Soap, soda and bleach costs are reduced as much as 75%. Fabrics are washed clean and snowy, and with the gentle care of soft water their life is increased 20% to 50% according to actual records. Lasting good will, promoted through attractive soft water laundering, is a truly worthwhile extra dividend too.

The Elgin is the only softener that gives you the exclusive "Double-Check" design which provides up to 44% more soft water per regeneration than others of equal size utilizing the same type zeolite. Costly zeolite loss is prevented too. With all types of zeolite, and with manual, semi-automatic or fully automatic models from which to choose, there is an Elgin to meet any need — any budget.

How to get 3 to 10 times more soft water from your present water softener

By simply equipping your present water softener with a "double-check" manifold arrangement, its zeolite capacity can be increased as much as 44%. But this, mind you, assumes the same kind of zeolite. If, as in so many cases, your zeolite is the old ineffective type, total replacement of it with Elgin high capacity zeolite may step up your soft water output *three to ten times.*

Write for Bulletin 611C

or let us have our nearest representative call

ELGIN SOFTENER CORPORATION

144 N. GROVE AVENUE, ELGIN, ILL.

REPRESENTATIVES IN PRINCIPAL CITIES
IN CANADA: G. F. STERNE & SONS, LTD., BRANTFORD, ONTARIO

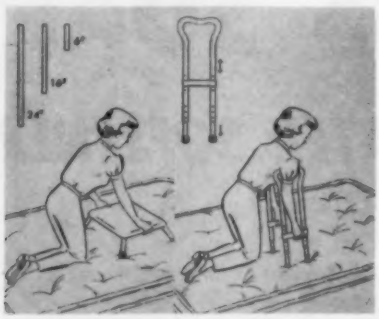
For additional information, use postcard on page 279.

Resin Emulsion Floor Finish Is Non-Slip When Wet

A new polymer floor finish of the resin emulsion type is announced in Poly-Kote. The new synthetic material has proved to be non-slip even when wet and has a high resistance to water spotting. It can be maintained by buffing and in heavy traffic areas it can be patched without build-up. **Hillyard Chemical Co., St. Joseph, Mo.**

For more details circle #382 on mailing card.

Crutches and Bench Facilitate Mat Therapy



Three-position adjustment hand grips on the Rehabilitation Mat Crutches facilitate their use in mat therapy. The legs are easily and securely adjusted to 30, 32 and 34-inch heights. The crutches are ruggedly constructed of chrome-plated alloy tubing for years of service.

Also new in the line of mat therapy devices is a mat bench with interchangeable leg heights for mat exercises or knee walking. It has plastic covered foam rubber top and is ideal for use with a wheel chair. It is constructed of six inch alloy tubing and hardwood with rubber tipped legs. The bench is available in sizes for child or adult. **Rehabilitation Products, Evanston, Ill.**

For more details circle #383 on mailing card.

High-Speed Centrifuge Is Quiet in Operation

Outstanding features of the new International Hematocrit Centrifuge include quiet operation and quick stopping. The new braking system allows the unit to come to a complete stop within 15 seconds from its high speed of 12,300 rpm's. The machine employs centrifugal force to separate plasma from corpuscles in blood and is so quiet in operation that a telephone conversation can be carried on next to the operating unit. Manufactured for durability, the machine has a heavy duty motor and rugged shaft and key components. A new precision reader adaptable to all capillary tube lengths and with a magnifying glass and light under the top for fast and accurate settings is also available. **International Equipment Co., 1284 Soldiers Field Rd., Boston 35, Mass.**

For more details circle #384 on mailing card.

Custom-Modular Cafeteria of Stainless Steel with Continuous Top

Modular base construction combined with continuous custom tops provides standardization with flexibility in the new stainless steel Bastian-Blessing Custom-Modular Cafeteria Equipment. The line permits the design of a cafeteria layout to meet individual requirements at minimum cost. The equipment is designed for use in every type of cafeteria application with modular base units produced to fit any layout. Limitless possibilities are permitted in length, arrangement and layout.

The continuous tops are built with the same freedom from dirt-catching cracks and crevices found in custom built tops. The decorator counter fronts are available in a wide variety of Formica and other plastic laminates with extruded aluminum along the bottom edge and rear surface covered

with Formica to prevent water damage. The Vapormatic automatic moist heat food warmer which requires no manual filling and operates without steam is included with the Dial-a-Food control. Soda fountain units are also available as part of the Custom-Modular cafeteria equipment. **The Bastian-Blessing Co., 4203 W. Peterson Ave., Chicago 46.**

For more details circle #385 on mailing card.

(Continued on page 254)

Combination lavatory fitting

Center-set lavatory fitting

Built-in service sink fitting

American-Standard hospital fittings are dependable, serviceable, easy to use and keep sanitary...

More and more hospitals are looking to American-Standard for a complete, versatile line of quality fittings to help them maintain peak efficiency.

These dependable American-Standard fittings are specially designed to meet the many requirements of hospital use. Hand, knee or foot controls . . . no matter what you need, American-Standard has it. All are finished in sparkling, non-tarnishing Chromard, which is easy to keep clean and sanitary. Modern in style and function, these top-grade fittings, like all American-Standard hospital equipment, offer lasting, dependable, economical service.

FOR MORE INFORMATION call your representative, or write AMERICAN-STANDARD, PLUMBING AND HEATING DIVISION, 40 W. 40th Street, New York 18, N. Y.

American-Standard & "Standard" are trademarks of American Radiator & Standard Sanitary Corporation

AMERICAN-Standard

PLUMBING AND HEATING DIVISION

For additional information, use postcard on page 279.

Phototimer Scanner for Spot Film Work

A plate of Plexiglas with a central area treated to glow when exposed to x-rays forms the new Westinghouse Verithin phototimer scanner. The x-ray exposure monitor for spot film work is encased in a light plastic housing. It is only ⅜ inch thick and is located to keep the spot-film device slim and uncluttered.

The new scanner is completely and permanently sealed against room light, dust, barium and other foreign materials. It provides for both conventional and Fluorex spot films, eliminates need for special phototiming cassettes, assures constant density and is easily serviced. **Westinghouse X-Ray Dept., Baltimore 3, Md.**

For more details circle #386 on mailing card.

Heavy Duty Vacuum Features By-Pass Motor

The new E-Con-O-Vac line of vacuum cleaners offers efficient operation with economy. Model 88 features a powerful 1¼ h.p. air cooled by-pass motor with intake and exhaust openings in the durable, integral cast aluminum head. It is excellent for both wet and dry pickup and can be used as a vacuum or as a powerful blower. Model 88 has a convenient push-pull handle and recessed carrying handles as well as an attached utility basket. It has a water lift of 66 inches and a tank capacity of 19 gallons. **General Floorcraft, Inc., 421 Hudson St., New York 4.**

For more details circle #387 on mailing card.

Channel and Private TV and Radio for Patients With Televiewer

A combination Television-Radio-Closed Circuit System is provided for hospital patients in the new Dahlberg Televiewer. The system is now available for regular channel broadcasts and telecasts as well as those originating in the hospital, all received over wall-mounted unit in the patient's room.

Each patient is supplied with an individual Master Pillow Speaker with built-in controls which regulate the television, radio and closed circuit programs for volume, fine tuning and contrast. He can thus listen to programs without disturbing others. The patient merely depresses a button and the set switches from channel to channel, to three radio station selections or to the hospital's closed circuit system. Units of the system are carefully engineered, comfortably and attractively designed and efficient in operation. **The Dahlberg Co., Golden Valley, Minneapolis 27, Minn.**

For more details circle #388 on mailing card.

Cardiological Equipment for Operating Room Diagnosis

A complete line of matched equipment for constant diagnosis in the operating room is now available in Futura Cardiological equipment. The seven-piece line includes a diagnostic electro Cardioscope, a variable-tone Cardiophone, a Defibrillator, the Pacemaker for muscular contraction of the heart, the electro Cardio-Tone, a precision Temperature Monitor, and an EEG Pre-Amplifier.

The complete matched set eliminates waste of time when cardiac accident occurs during surgery. The Dallons Life-Saving-Team is ready for immediate use, whatever the cardiac problem may be. The Futura line is modern in design and appearance. It is distributed internationally by **Ohio Chemical and Surgical Equipment Co. of Madison, Wisconsin,** but is manufactured by **Dallons Laboratories, Inc., 5066 Santa Monica Blvd., Los Angeles 29, Calif.**

For more details circle #389 on mailing card.

(Continued on page 256)

tonic for crowded hospitals

A "pleasant to take" way of making private rooms out of ward beds.

Designed *exclusively* for hospitals, ARNCO CUBICLES are completely unobtrusive . . . do not conflict with lighting or wall fixtures . . . eliminate interference with doors or windows. Patients are assured of privacy and adequate ventilation. Sturdily constructed, ARNCO CUBICLES provide longer service, because the zinc die cast axle provides extra carrier strength – has bead chain for flexibility and rust-proof curtain hook. No sliding or binding friction to interfere with smooth and easy operation.

NEW NON-CONTACT NYLON ROLLER NOW ON ALL CUBICLES

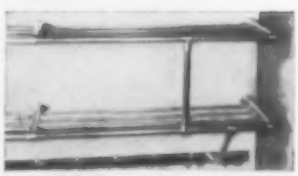
HEAVY DUTY TRACK FOR RUGGED HOSPITAL USE

EXCLUSIVE ARNCO CEILING TRACK MAY BE FLUSH OR SURFACE MOUNTED WITH EITHER PLASTER OR ACOUSTIC CEILING

There's no better "medicine" for crowded hospital wards than ARNCO CUBICLES. Why not investigate their advantages today? Write for details.

ARNCO Cubicles are also available in the suspended type

Curtain Replacements for Cubicles in pastel shades. May be flameproofed, if desired.



NEW! Low Cost Rack sturdily made in non-peeling alumilite finish . . . this easy to install coat and hat rack, or storage shelf finds innumerable uses in hospitals. Write for literature.

A. R. NELSON CO., INC.

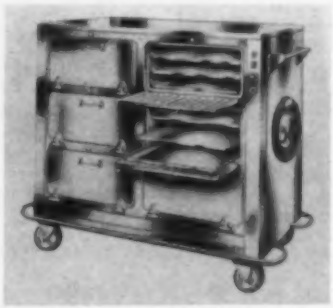
38-35 Crescent St. • Long Island City 1, N.Y.

For additional information, use postcard on page 279.

Mobile Thermotainer Carts Handle Many Food Service Needs

Several new Thermotainer food carts are now available from Franklin Products. Illustrated is the Type TJ-6 Thermotainer with six large compartments with stainless steel sliding shelves. It has a capacity of seventy-two 10-inch dinner plates or eighteen 16 by 22-inch trays. Each compartment is equipped with a damper for moisture control and one thermostat controls all compartments.

The Type T-1 Thermotainer Mobile Food Cart has one unheated and two heated compartments. The large compartment size permits use of trays, pans and



plates. A third mobile cart is the Type TC-6 for moving large quantities of hot food from the kitchen to the serving area. Each of the six large compartments is equipped with two pair of adjustable and removable stainless steel angle slides. All carts are of heavy gauge stainless steel construction with rubber tired casters, push bars and rubber bumpers. **Franklin Products Corp., 400 W. Madison St., Chicago 6.**

For more details circle #390 on mailing card.

Plastic Enema Tips Are Disposable

A sanitary product made of polyethylene plastic is available in the new "N-tips" disposable enema tips. Made to be used once, then discarded, "N-tips" save cleaning and sterilizing while eliminating the possibility of cross infection. The specially designed sloped head facilitates insertion and assures effortless retention and simple withdrawal. "N-tips" can be used with barium or any enema solution and are sterile wrapped in individual polyethylene bags, ready for immediate use. **Wolf X-Ray Products, Inc., 93 Underhill Ave., Brooklyn 38, N.Y.**

For more details circle #391 on mailing card.

Measurement of Chloride Content Simplified With Titrator

The Aminco-Cotlove Chloride Titrator is a new instrument designed for measuring chloride content in biological samples. It is designed so that the concentration of chloride in solution can be repeatedly and accurately determined. The new titrator makes possible the measurement of chloride contents of serum or plasma, spinal fluid, urine, culture media, tissues and the like at titration times below sixty seconds. The extremely sensitive instrument offers numerous advantages and ensures accurate results. **American Instrument Co., Inc., 8030 Georgia Ave., Silver Spring, Md.**

For more details circle #392 on mailing card.

(Continued on page 258)

The simple beauty of the new wing of St. Luke's Hospital is maintained by the trim appearance of General Electric *Thinline* air conditioners mounted inside the windows.

163 General Electric Thinline Air Conditioners Cool and Filter the Air in This Wisconsin Hospital

"AIR CONDITIONING means more than personal comfort to us," says Karl York, administrator of St. Luke's Hospital in Racine, Wisconsin. "Patients relieved of discomfort are better patients, and the better the patient, the quicker the recovery.

"Our employees are happier and more efficient, too."

General Electric *Thinline* air conditioners were donated to St. Luke's by a former patient who had sweltered in a hospital bed through many hot, humid summer days. Air-borne dust, dirt and pollen are almost entirely eliminated.

No one swelters at St. Luke's today. Both new and old sections of the hospital are cooled and ventilated by an air conditioning system that uses *Thinline* units in four different types of installations.

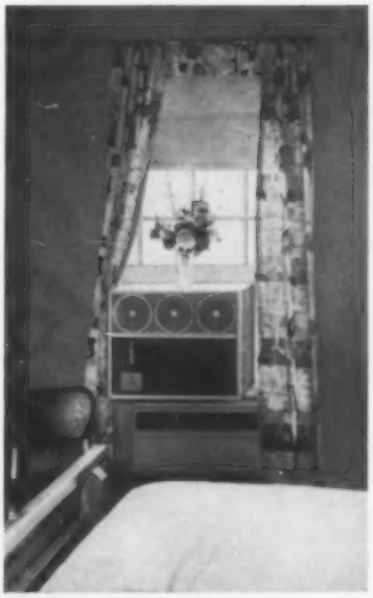
Two *Thinline* air conditioners are built into glass block walls; one is mounted in a metal casement window; six others are mounted completely outside double-sash windows; and the remaining 154 are inside double-sash windows.

This system assures cool comfort and maximum cleaning convenience for each cooling zone in the building.

Whether yours is a new or existing building, why not look into the advantages of air conditioning with General Electric *Thinline* units. Various models are available from 5600 to 14,500 BTU* capacity. There's one just right for your cooling needs.

See your General Electric representative for full details. General Electric Company, Appliance Park, Louisville 1, Ky.

*Cooling capacities are tested and rated in compliance with ARI (Air Conditioning and Refrigeration Institute) Standard 110-58 and are stated in BTU's (British Thermal Units).



Window-mounted *Thinline* units allow enough light to keep hospital rooms bright and cheerful. Many hospitals rent these units to patients as an added source of revenue.

Progress Is Our Most Important Product

GENERAL ELECTRIC

For additional information, use postcard on page 279.

Hot Chocolate Mix in Liquid Form

Liquid Hot Chocolate Mix is a new product in thick, syrup form containing chocolate, milk and sugar. It produces a thoroughly dissolved cup of hot chocolate with the addition of hot water. The mix is carefully homogenized and may also be used as a topping for ice cream. Packaged in glass jars in pint and quart sizes, the new product is used with five parts of water to one part of mix. **Continental Coffee Co., 2550 Clybourn Ave., Chicago 14.**

For more details circle #393 on mailing card.

Band-Aid Clear Tape Now in Professional Rack Rolls

Clear, transparent plastic surgical tape known as Band-Aid Clear Tape is now available in Professional Rack Rolls for hospital use. It combines hypo-reactive properties with stretch and conformability. The tape is waterproof and washable, oil and grease wipe off easily, and its non-glossy surface is virtually invisible on the skin. Professional Rack Rolls are now available in narrow, medium and wide Band-Aid Clear Tape. **Johnson & Johnson, New Brunswick, N. J.**

For more details circle #394 on mailing card.

Efficient Cylinder Carrier Conserves Space

Space in handling and in storage is saved with the new cylinder cart developed by National Cylinder Gas. The welded base plate is formed to fit around the lower part of the cylinder body, putting the center of gravity directly between the wheels. It is mounted on two semi-pneumatic tires and two swivel casters for complete ease of handling without danger of upset. The carrier is moved or turned by gentle pressure on the upper part of the cylinder itself. By raising the rear casters until the base-plate

is at floor level, cylinders are easily placed on or taken off the cart. The new carrier can be stored in a space as small as 18 by 24 by 24 inches. **National Cylinder Gas Div., Chemetron Corp., 840 N. Michigan Ave., Chicago 11.**

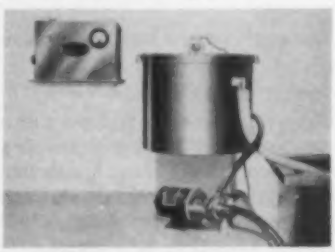
For more details circle #395 on mailing card.

Surgical Instrument Line of Swedish Stainless Steel

The new line of Aloe-Swedish Stainless Steel surgical instruments offers highest quality materials, craftsmanship and design with low cost. American patterns were used to build a line of light, gracefully curved yet stable instruments meeting the requirements of American surgeons. They are formed of the finest Swedish steel, with low-carbon, high-chromium content, crafted in the Aloe plant in West Germany which is staffed by craftsmen with a lifetime of experience in instrument-making. Rigid inspection assures a line of finest quality instruments. **A. S. Aloe Co., 1831 Olive St., St. Louis 3, Mo.**

For more details circle #396 on mailing card.

Inexpensive Silver Recovery Unit Operates Automatically

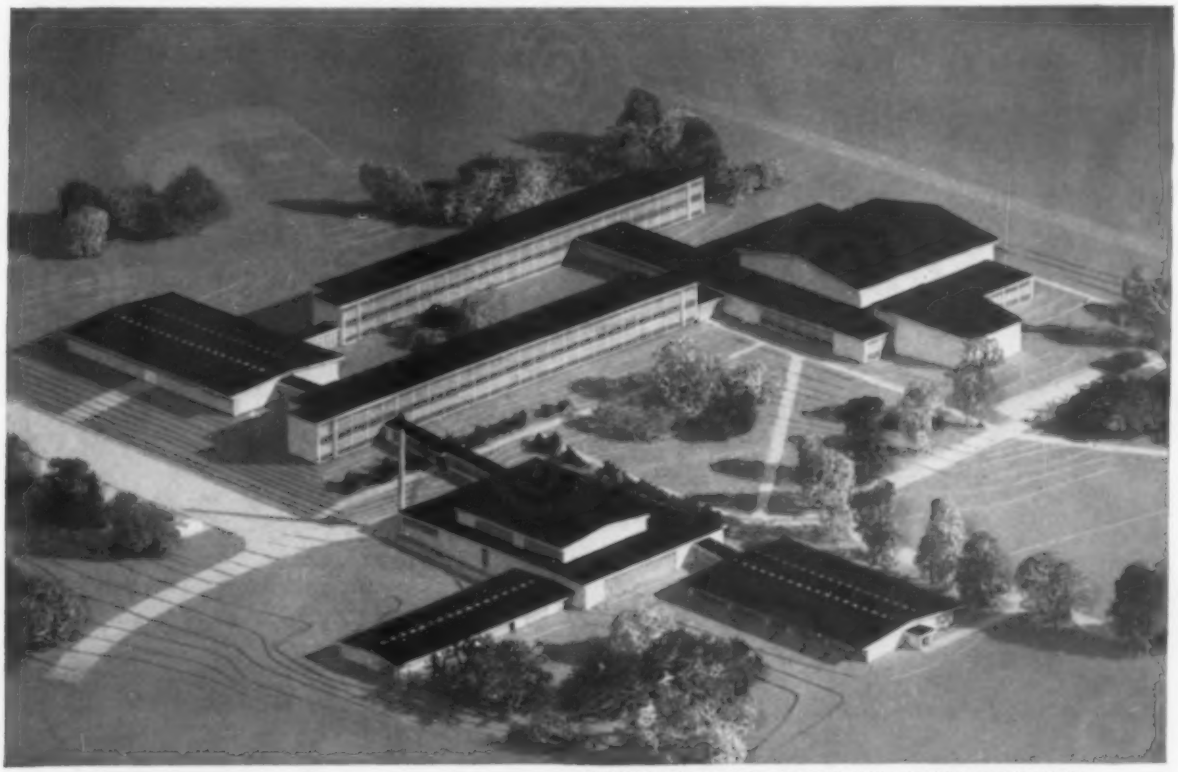


Virtually automatic operation is a feature of the new Model 0-57 Silver Recovery Unit. It is plugged into an ordinary current outlet and may be left to operate during hours when the laboratory is unattended. Functioning electrolytically, the unit gathers silver from film at the rate of one ounce per hour and operates at a cost of only a few cents. It is designed to take up minimum space, with the control box mounted on a wall or shelf and the centrifugal pump stored out of sight. **Oscar Fisher Co., Inc., P. O. Box 426, Newburgh, N. Y.**

For more details circle #397 on mailing card.

(Continued on page 262)

A continuing series of outstanding schools, churches, office buildings, hospitals and industrial structures using NORTON DOOR CLOSERS



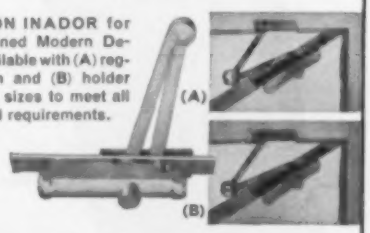
HAARSTICK LUNDGREN AND ASSOCIATES INC.—ARCHITECTS, ENGINEERS
HARDWARE DISTRIBUTOR: WHEELER HARDWARE CO., ST. PAUL, MINN.

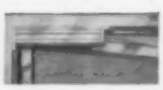
SCHOOL PLANNING THAT LOOKS AHEAD SPECIFIES NORTON DOOR CLOSERS

Burnsville School—Independent District No. 191—Savage, Minnesota

Complete Norton Line Meets Every Door Closer Need

NORTON INADOR for Streamlined Modern Design available with (A) regular arm and (B) holder arm...4 sizes to meet all standard requirements.





NORTON 750: New corner design with concealed arms for all type doors, particularly narrow rail doors.

Norton Surface-type Closers are available for all installations where concealment is not essential.

NORTON 703E: Compact surface mounted type...first closer with extruded aluminum alloy shell.

Here's an outstanding new school building—the result of plans that were made to meet some twenty carefully considered objectives. Among them: (1) The building must be functional; modern beauty without waste. (2) It must be of good materials to stand the test of time. These two factors governed selection of door closers.

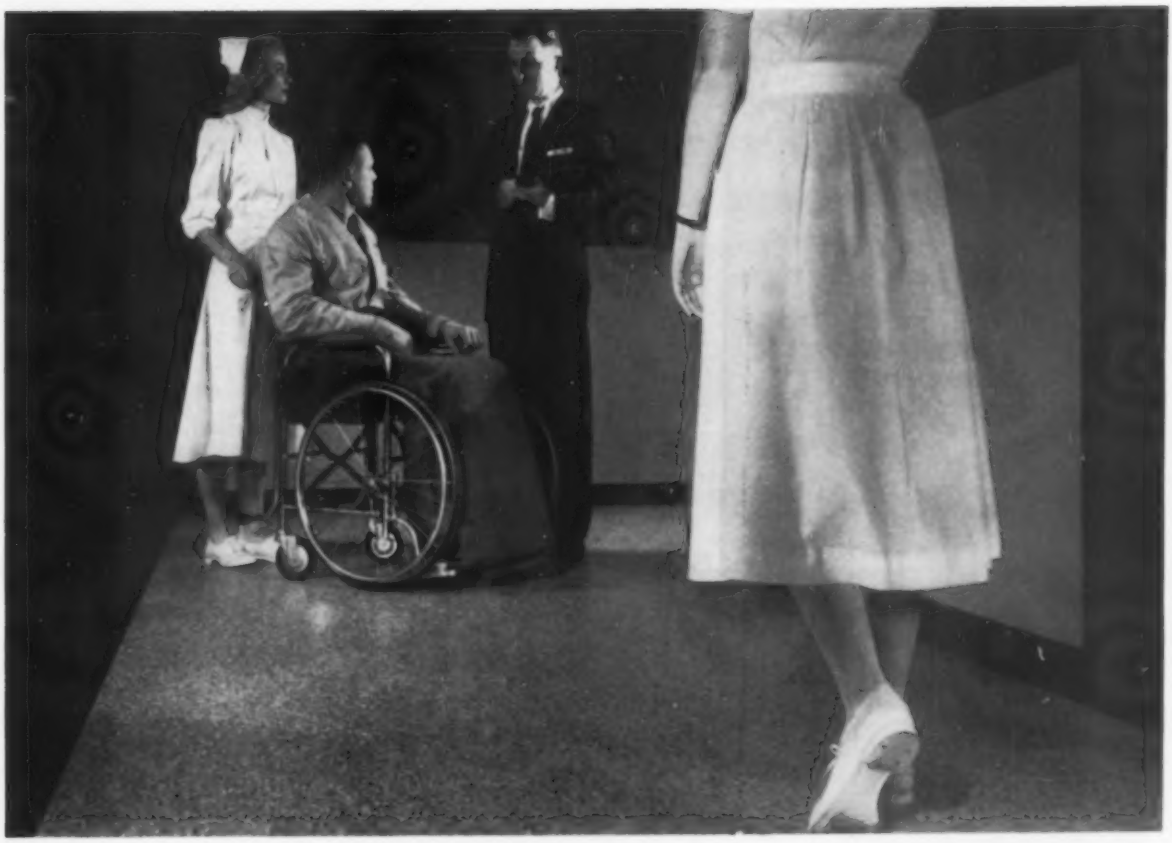
Interior doors have NORTON INADOR Closers mortised into the top rail. Their compact, fully concealed mechanism packs all the rugged dependable power of true liquid-type closers plus the reliability, low maintenance and precision workmanship common to all *Norton Door Closers*.

Exterior doors use Norton Surface-Mounted Closers, modern counterparts of Norton Closers still in daily use after serving continuously up to 30 years and longer in some of America's most famous public buildings. For fully illustrated data on these and other models, consult the current Norton Catalog. Write for it today.

NORTON® DOOR CLOSERS

Dept. MH-98 • Berrien Springs, Michigan

For additional information, use postcard on page 279.



Congoleum-Nairn HAS THE RIGHT PRODUCT FOR EVERY HOSPITAL FLOOR NEED

1. **For corridors, sickrooms, wards and heavy traffic areas**—Congoleum-Nairn ⅛" Inlaid Linoleum, with colors clear through to the backing, assures years of wear even in areas of heaviest traffic. Durability proven by installations in constant use after more than 25 years. Available in classic Veltone® or exciting new Sequin® in a full color range. Easy-cleaning surfaces resist grease and grime, hide scuffs and scratches. 6′ widths provide virtually seamless floors, fewer germ-breeding cracks.

2. **For X-Ray and operating rooms**—Congoleum-Nairn Static-Conductive Linoleum, an exclusive Congoleum-Nairn product that prevents static electricity hazards. Tested and approved for danger areas in famous hospitals throughout the country. Meets the requirements of the Underwriters' Laboratories, Inc. and the National Fire Protection Association.

3. **For waiting and reception rooms**—Congoleum-Nairn Nairon* Custom Tile, the full-thick homogeneous vinyl plastic tile with built-in dimensional stability. Exceptionally resilient and comfortable, it withstands heaviest loads. Resists stains, dirt, and solvents. Available in ⅛" and .080" gauge.

4. **For "problem" floors**—Congoleum-Nairn Vinylbest* Tile, a versatile blend of vinyl and asbestos that literally can be installed anywhere—ideal for areas where seepage and moisture create problems. Now in new Feathervein decoration. Same strength **all** the way through.

5. **For noisy areas**—Congoleum-Nairn Rubber Tile, supreme in resilient, silent comfort. Long-wearing and resistant to indentation, yet so quiet and easy underfoot.

6. **For ground-level and basement floors**—Congoleum-Nairn Asphalt Tile, handsome and practical for basements and other areas where concrete flooring is in direct contact with the ground. This economical tile shrugs off alkalinity. Now in new Feathervein decoration. Same strength **all** the way through.

FOR HOME . . . BUSINESS . . . INSTITUTIONS:

BY THE YARD AND TILES—Inlaid Linoleum • Nairon ® Plastics Vinylbest* Tile • Cork Tile • Rubber Tile • Asphalt Tile
PRINTED FLOOR AND WALL COVERINGS—Congoleum® Congowall® and Forecast Vinyl®
SATISFACTION GUARANTEED OR YOUR MONEY BACK

GOLD SEAL

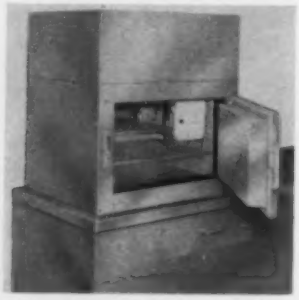
Congoleum-Nairn
FINE FLOORS

*Trademark

For additional information, use postcard on page 279.

Laboratory Refrigerator Is Counter Model

Model OC-4 is an over counter refrigerator providing easy access to biologicals and specimens in the laboratory. The condensing unit is at the top of the refrigerator so



that the unit may be placed flush to the wall and both interior and exterior are of stainless steel. A two-tray ice cube coil, perforated stainless steel shelves and chrome-plated hardware make the unit ideal for the laboratory. The overall size is 30 inches wide, 24 inches deep and 34½ inches high. **The Jewett Refrigerator Co., Inc., 2 Letchworth St., Buffalo 13, N. Y.**

For more details circle #398 on mailing card.

Scottie Folding Wheel Chair Features Quality and Price

Low price with quality are features of the new Scottie folding wheel chair. The chair was carefully developed and endurance tested under severe conditions. The arm design permits close approach to areas of use, the folding aluminum footrests are adjustable in height and the cross members are out of the way of feet and legs, yet permit ease of folding. The slip-in, brown plastic covered reinforced upholstery gives even support with comfort and the Flex Ride chassis is shock-absorbing. Ball bearing, rubber tired wheels and five-inch swivel casters make the chair easily maneuverable. It folds into 10-inch width. **Institutional Industries, Inc., 5500 Muddy Creek Rd., Cincinnati 38, Ohio.**

For more details circle #399 on mailing card.

Odor Neutralizing Chemical for Air Conditioning

A deodorant and air freshener for use in air conditioners and heating systems is introduced in Eastonair. A new form of odor neutralizing chemical compound, Eastonair is solid in structure and has a controlled evaporation cycle under both winter and summer conditions. It is easily installed in all models and types of air conditioning units, is odorless, non-toxic and non-irritating and will freshen stale air. **Easton R. S. Corp., 876 Pacific St., Brooklyn 38, N. Y.**

For more details circle #400 on mailing card.

Sonogen Ultrasonic Cleaner for Surgical Instruments

The Model H-50 Sonogen Cleaner is a self-contained ultrasonic installation for cleaning, immersion or spray rinsing of hospital equipment. It cleans quickly, removing protein, tissue and other contaminants thoroughly. Test tubes, syringes, hypodermic needles, glassware and instruments can be cleaned in the unit which is installed by connecting to hot and cold water, drains, and a regular current source. The unit is

27 by 36 by 42 inches in size with a counter top area of 21 by 36 inches. **Branson Ultrasonic Corp., 40 Brown House Rd., Stamford, Conn.**

For more details circle #401 on mailing card.

(Continued on page 264)

New patented CAVITY TILE*

Brings You Quiet at New Low Cost!

Perfected in Acousti-Celotex research laboratories, this new kind of sound conditioning *combines every feature* you look for in a hospital ceiling:

(1) high sound absorption that puts a hush on noise in corridors, wards, nurseries, labs, service areas, private rooms, surgery, offices, cafeterias; (2) incombustibility . . . carries UL label; (3) repaintable time after time with no loss of sound absorbing efficiency; these perforations won't clog! (4) instantly removable, for access to area above; (5) attractive . . . clean, smooth pure white surface; (6) economical . . . one of our lowest-cost suspended ceiling materials.

For demonstration and estimate, without obligation, call your Acousti-Celotex distributor. He's listed in the Yellow Pages.

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Products to Meet Every Sound Conditioning Problem . . . Every Building Code
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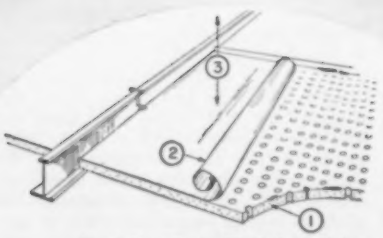
Without cost or obligation, please send me your new brochure on Cavity Tile and the name of my nearest Acousti-Celotex Distributor.

Name _____ Title _____

Firm _____

Address _____

City _____ Zone _____ State _____



Here's How Cavity Tile Reduces Noise:
Airborne sound waves enter perforations in (1) special gypsum board tile . . . are partially converted into thermal energy in transmission through (2) special membrane laminated to back of tile . . . are further dissipated by the "spring-like" action of the (3) air space (cavity) above.
RESULT: permanently high noise reduction efficiency

Basic Isotope Laboratory Has Four Units

The Isolab is a basic medical isotope laboratory consisting of four units. Designed to meet present and future needs, the Isolab has a mobile cabinet console, counter-balanced arm that rotates 360 degrees in any plane, transistorized scintillation counter and a decade scaler.

The basic equipment included in the Isolab permits operation of a limited radioisotope program, including thyroid and pernicious anemia diagnosis and localization of metastatic masses. Extra compartments are provided in the console for additional instruments which can be added as required for handling practically any diagnosis or therapy in which isotopes are used. The new system offers convenient, economical,

built-in flexibility. **Nuclear Measurements Corp., 2460 N. Arlington Ave., Indianapolis 18, Ind.**

For more details circle #402 on mailing card.

Dishwasher Rinse Injector Prevents Water-Spotting

A measured amount of Diversey Zerospot additive is injected automatically into the final rinse spray in dishwashing machines with the new Rinsemaster. Water spotting and streaking is prevented since surface tension of the rinse water is reduced for rapid drying. The improved Rinsemaster has no moving parts and operates at water pressures as low as two pounds or up to 80 pounds, adjusting automatically to any change. **Diversey Corp., 1800 W. Roscoe St., Chicago 13.**

For more details circle #403 on mailing card.

Portable Disposalls For Heavy Duty Waste Burning

Four to six drums of waste can be burned in a day with the new Goder Heavy Duty Deluxe Disposalls. The large sized portable units were especially designed for handling institutional waste with minimum effort. The inclined front closing door on the new models is operated by the E-Z foot pedal which leaves the hands free to handle the waste drums.

A series of inclined, staggered step grates keeps the waste material moving

downward, with precisely sufficient oxygen exposure for an all-consuming fire. Smoke, odor and heat loss are reduced. The secondary combustion chamber completely destroys all remaining residue as well as fly ash. The new Disposalls are ruggedly constructed and available to provide three burning capacities. **Joseph Goder Incinerators, 4241 N. Honore, Chicago 13.**

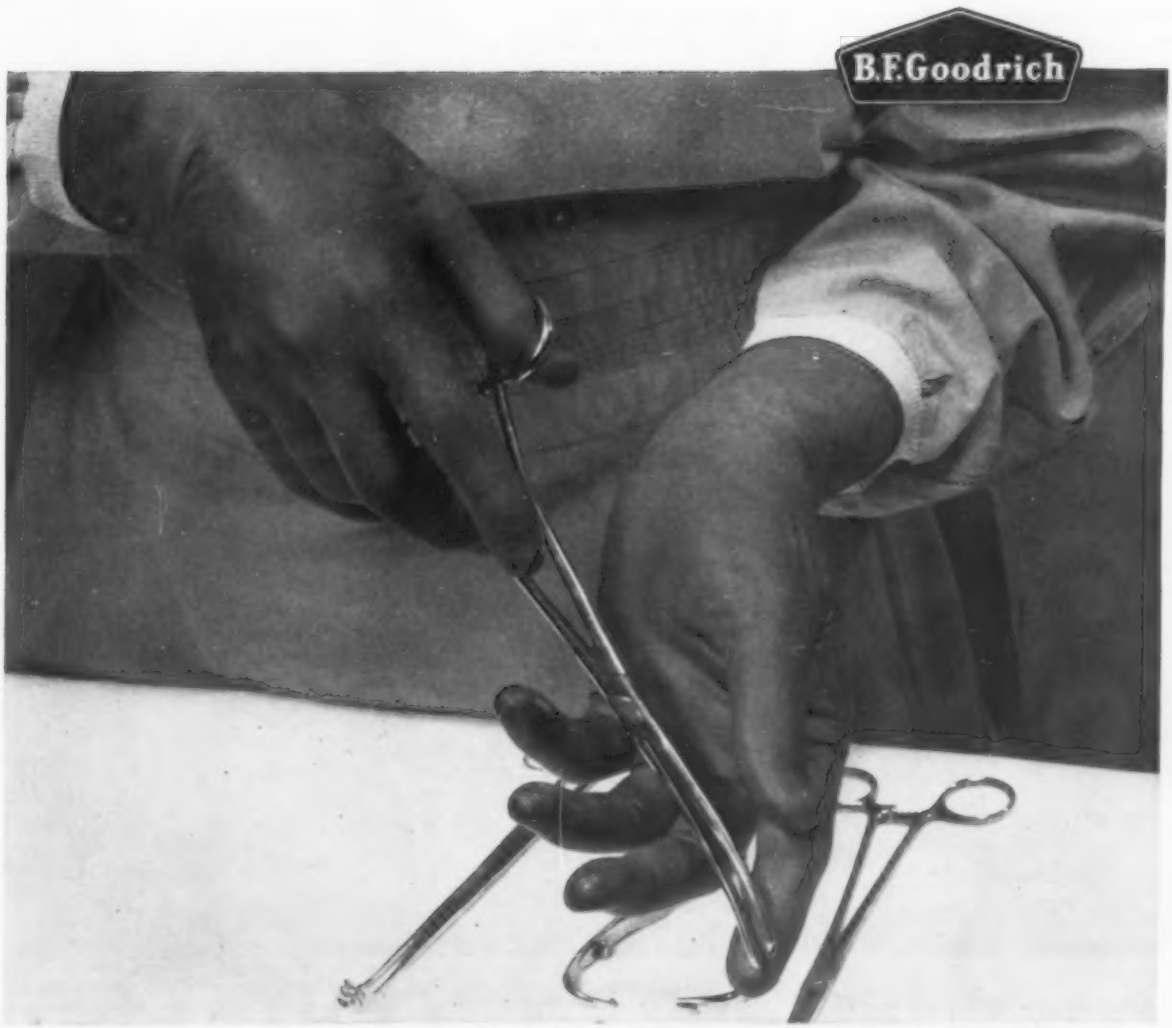
For more details circle #404 on mailing card.

Dehydrated Onions in Institutional Pack

No. 10 tins of Dehydrated Onions are now available in two sizes, sliced and chopped, for institutional use. Each can lists raw equivalents and gives complete directions for use. Advantages of the dehydrated product, in addition to elimination of the discomfort of preparation, include savings in preparation time, in storage space and in waste, uniform high quality, flavor strength and ready availability. Prepared to meet the high standards of the American Dehydrated Onion and Garlic Association, the institutional sized packs are available through the **Institutional Div., McCormick & Co., Inc., 414 Light St., Baltimore 2, Md.**

For more details circle #405 on mailing card.

(Continued on page 166)



Still strong and comfortable after many autoclavings

B.F.GOODRICH "Surgiderm" gloves continue to give good service even after a dozen autoclavings. The use of a specially-developed rubber compound makes this glove 36 per cent stronger than an ordinary surgical glove before use, 67 per cent stronger after ten sterilizations. Since these gloves stay stronger longer, they can be used more times, cost less per operation.

The B.F.Goodrich "Surgiderm" glove is much softer than any regular rubber surgeons' glove. Because it's more pliable, it takes less force to flex the fingers and hand, a tremendous factor in reducing operating fatigue. The difference in comfort is so obvious you can feel it just by putting this B.F.Goodrich glove on one hand and comparing it with any other rubber glove on your other hand.

Some gloves being sold today are extra soft—or extra strong—or extra sensitive. But the only glove to combine all three of these benefits is the "Surgiderm" by B.F.Goodrich. While you might expect such a glove to be expensive, it actually costs no more than many standard brands now on the market. And it's your most economical buy because it can be used for more operations.

It is made in sizes from 6 to 10, is brown in color. Color markings and large numerals show sizes for fast, accurate sorting. Sold by hospital supply houses and surgical dealers everywhere. *Hospital and Surgical Supplies Dept., The B.F.Goodrich Co., Akron 18, O.*

B.F.Goodrich ***hospital and surgical supplies***

Symmetry Unit Room Furniture Has All Laminate Surfaces

Nevamar high-pressure laminates form both inside and outside surfaces of the new Symmetry unit furniture for hospitals and nurses' homes. Six attractive basic units with other units of varying sizes and types are combined to fill furniture needs for any sized room. Units are 29 inches high, the

smallest with an 18-inch square top. Headboards are also available as part of the Symmetry group.

Nevamar non-porous surfacing material does not chip, crack or peel and requires no painting or refinishing. It is vermin-proof and unaffected by alcohol, fruit acids, ammonia, ordinary ink and other materials and can be cleaned by wiping with a damp cloth. The furniture units feature smoothly sliding drawers, square tubular legs securely anchored, sealed edges, warp-proof panels and reinforced joints. Symmetry is available in Oyster Ash or Platinum Oriental Walnut as well as other attractive patterns. **National Store Fixture Co., Inc., Odenton, Md.**

For more details circle #406 on mailing card.

Cushion-Eze Tackboard Has Foam Rubber Cushioning

Easy tack removal and insertion is possible with the new Cushion-Eze Tackboard material. Foam rubber cushioning and a patented synthetic rubber and fiber composition permit repeated use in one spot without damage to the tackboard. The material is lightweight, has sound absorptive qualities, is attractive in appearance and extremely flexible. It is easy to install without the possibility of cracking or breaking, even if folded double.

Cushion-Eze Tackboard is available in three modern pastel colors: Coppertone Tan, Driftwood Grey, and Mint Green, and is supplied in continuous rolls of 48 and 72-inch widths. It may be cemented to any solid wall or to a rigid backing as desired. **Armstrong Cork Co., Lancaster, Pa.**

For more details circle #407 on mailing card.

Garbage Disposer Line Is Redesigned for Versatility

The versatile line of Waste King commercial garbage disposers and accessory components is redesigned for greater simplicity and efficiency of operation. Composed of six basic model disposers, the new line features a new silver guard and scrapping system, two bowls, three bowl covers, two swirl sprays, four overhead spray rinses, and a reduced number of switches, valves and other fittings.

The new components will be used to form 17 basic equipment groups designed to meet almost all institutional requirements for a dishtable or all-purpose disposer installation. The new disposers and accessories are so designed that they can be assembled in combinations to meet any specialized requirements, regardless of type or size. The new line has been under development for more than two years and includes quiet operation, long life, easier installation and maintenance and elimination of external wiring. **Waste King Corp., 3300 E. 50th St., Los Angeles 58, Calif.**

For more details circle #408 on mailing card.

Radiation Shielding Window Engineered as Package Unit

Built to Argonne National Laboratories' specifications by Research Equipment Company, zinc bromide radiation shielding windows are now available as a packaged unit. The pre-engineered package includes glass, frame, liner, solution and installation instruction manual. The window comes complete, ready for mounting in a concrete wall of the radiation room. The glass is sufficiently thick to confine the zinc bromide solution and the inside panel is a non-browning glass to prevent discoloration from radiation. Operating personnel, physicians and others can view patients receiving radiation therapy from Cobalt 60 or other isotopes without danger, and the patient is relieved of undue apprehension by

seeing doctor or nurse at the window. The use of zinc bromide solution reduces the cost of shielding windows for radiation rooms, yet they shield equal to a solid concrete wall and light transmission is high. **Research Equipment Co., 1032 College Ave., Wheaton, Ill.**

For more details circle #409 on mailing card.

Dual Fibre-Glass Light Shade Protects Against Heat

Three models are available in the new hospital bed light with internal alzak reflector and a protecting dual Fiber-Glass shade. They are never too hot to handle in positioning the lamp. Model S No. 3010 is a complete unit designed to supply all the lighting requirements for the patient area at an economical price. It combines indirect illumination with instantly adjustable localized lighting where needed by patient, nurse or doctor, and serves as a permanent fixture, completely flexible and constructed of durable materials.

Model D No. 3020 has direct light extension of 40 inches with an intermediate swivel providing complete position control. Model O No. 3000 provides direct light for nursing homes, dormitories, large wards, local examination and students' rooms. All three lights have the heat protective shade for comfort in handling. **Luminous Equipment Co., 1325 W. Webster Ave., Chicago 14.**

For more details circle #410 on mailing card.

(Continued on page 268)

Water-Operated Lint Trap Eliminates Fire Hazard

Almost complete lint removal is claimed for the re-designed Olson patented water-operated lint trap. Maximum drier efficiency, and elimination of the fire hazard of dry lint from laundries are advantages of the unit which traps the lint in water. Wet lint is collected in a removable perforated galvanized basket at the end of a trap and is easily cleaned out. Engineering and design improvements assure maximum efficiency and the new models, available in two sizes, are constructed of heavy gauge galvanized steel. The traps can be placed on the floor or wall, or be suspended. **Techtmann Industries, 407 E. Michigan St., Milwaukee 1, Wis.**

For more details circle #411 on mailing card.

Asbestolux Building Board Acts and Works Like Wood

Composed of long fiber Amosite asbestos which is bonded under high pressure steam with top grade silica, the new asbestos building board known as Asbestolux acts and works like wood. It has a high percentage of asbestos fiber and in tests, it received a zero combustible rating.

The material can be sawed with ordinary hand saws or with workshop power equipment. It can be nailed or screwed without special preparation and otherwise worked with ordinary tools. It can be used as backing, for insulating surfaces, and as fire walls. It is resistant to rot, mold, vermin and corrosion. **North American Asbestos Corp., 3210 Board of Trade, Chicago 4.**

For more details circle #412 on mailing card.

Modern Metal Furniture for Waiting Rooms and Lounges

A complete line of contract furniture developed by Howell combines a coordinated selection of lounge furniture, including davenports, arm chairs, sectionals, ottomans, and double seat benches, with tables, desks and similar items. The line is suitable for use in reception rooms, lounges, nurses' homes, staff residences, offices, and in waiting rooms such as the "Stork Club" for expectant fathers shown in the illustration. The furniture is comfortable, sturdy and easy to clean.

Included in the new line are table tops in several wood-grain plastics, two-tone

inlay combinations and other designs in durable laminated plastic made to withstand institutional use. Chair frames and table legs of tubular steel are finished in Bronzetone or in Blactone. Upholstered pieces are available in a wide selection of upholstery covers, including plastics, fabrics and other materials. Cushions are of patented "No Sag" spring construction with reversible spring filled or foam rubber cushions. **Howell Co., St. Charles, Ill.**

For more details circle #413 on mailing card.

Sponge-Like Absorbency in Acme Cotton Balls

Long staple fibers of selected virgin cotton are used in forming the new line of Acme cotton balls with sponge-like absorbency. Use of the long fibers eliminates "wisks" or "strings." The new absorbent cotton balls are available in five sizes for such uses as application of medication, stoppers for bottles, test and culture tubes and capsule containers and for instrument and equipment cleaning. **Acme Cotton Products Co., Inc., 245 Fifth Ave., New York 16.**

For more details circle #414 on mailing card.

Silver Handling System Has Stainless Steel Cylinder

A high luster stainless steel cylinder is now available for heavy duty use in the Steril-Sil system of silver handling. The deep drawn one-piece cylinders have rounded corner base providing sanitary service since there are no seams where bacteria could lodge, and the scientific design ensures complete drainage. The new stainless steel cylinders for busy kitchens, as well as the nylon cylinders, are used for holding silverware, eating portions up, during washing. Silverware is transferred to clean empty cylinders, eating portions down, for transportation and service. **The Steril-Sil Co., 150 Causeway St., Boston 14, Mass.**

For more details circle #415 on mailing card.

(Continued on page 270)

Marietta Memorial Hospital exceeds Building Fund Goal by $12,877.00

Architect's drawing of Marietta Memorial Hospital, Marietta, Ohio. Recent Building Campaign, directed by Ketchum, Inc., raised $712,877 against a goal of $700,000.

. . . another successful 1958 hospital campaign directed by Ketchum, Inc.

Against a Building Fund goal of $700,000, Marietta Memorial Hospital, Marietta, Ohio raised $712,877 . . . an oversubscription of $12,877! This is the hospital's second successful campaign directed by Ketchum, Inc.

The outstanding success of the people of Marietta, Ohio was achieved in spite of a general business decline. Added to funds already on hand and Hill-Burton grants the hospital can now undertake an expansion program totalling $1,200,000.

At the conclusion of the campaign, Mr. Carl L. Broughton, General Chairman, had this to say about the service rendered by Ketchum, Inc.: "Our community will always be grateful to your staff for the skillful way in which it handled this campaign."

If your hospital is planning a campaign for funds this year or next, write now telling us of your problem. The importance of early counsel cannot be overstressed. You are under no obligation.

MEMBER AAFRC

KETCHUM, INC.

Direction of Fund-Raising Campaigns

CHAMBER OF COMMERCE BUILDING
PITTSBURGH 19, PA.

500 FIFTH AVENUE, NEW YORK, 36, N.Y.
JOHNSTON BUILDING, CHARLOTTE, 2, N.C.

For additional information, use postcard on page 279.

"Dura-Weve" Hand Towels Are Attractive and Disposable

Scott Paper Company's "Dura-Weve," a soft, strong and absorbent cellulose material which looks and feels like cloth, is used to form disposable hand towels made in a fine imitation of cotton "huck." The new towels are available in plain white, two stock prints, or personalized. The fully disposable towels have high absorbency, are sanitary and economical in use, and can be autoclaved. **American Lace Paper Co., 4425 N. Port Washington Ave., Milwaukee 12, Wis.**

For more details circle #416 on mailing card.

Refuse Container of Unbreakable Plastic

Unbreakable polyethylene plastic is used to form the new Lustro-Ware 8-gallon Refuse-Tainer, Model C-108S. The odor-sealing cover has a large molded handle for easy removal. The plastic protects floors and walls and is clatter-proof. The seamless construction is rustproof and leakproof and the Refuse-Tainer can also be used as a covered container for storage. It can be cleaned easily and sterilized with any disinfectant. The strong metal bail handle is anchored in polyethylene sockets. **Columbus Plastic Products, Inc., 1625 W. Mount St., Columbus 23, Ohio.**

For more details circle #417 on mailing card.

Deep Freeze Units for Cold Preservation of Grafts

A special unit, no larger than an average desk and requiring no installation but plug-in to a regular power outlet, water supply and discharge, is now available for preservation of human graft parts. The deep freeze units will keep constant temperatures of 40, 100 and 125 degrees below zero Fahrenheit and have a recording device which keeps a record of the temperature 24 hours a day. The unit can be kept on the surgical floor for storage of arterial segments, bone, skin or eyes for grafting purposes. **Tenney Engineering, Inc., 1090 Springfield Rd., Union, N.J.**

For more details circle #418 on mailing card.

Selective Radio Page Has Improved Case and Clip

Improvements have been built into the Motorola selective radio paging receiver for doctors and hospital personnel. A wider, stronger clip holds the pager on the belt or pocket of the individual and the new gray colored plastic case is unbreakable. A new

tone signal is also built into the receiver so that the doctor or department head will get the signal under any conditions.

The "Handie-Talkie" Radio Paging system gives private, individual paging anywhere in the hospital, only the individual being paged receiving the signal and message. The receptionist or telephone operator presses the proper selector button to activate a particular receiver, then speaks the message into a desk microphone. The transistorized receiver is slightly larger than a king size package of cigarettes and the FM reception is immune to common types of interference. Operating cost is low, batteries have long life, time is saved and efficiency is increased. **Motorola Communications & Electronics, Inc., 4501 W. Augusta Blvd., Chicago 51.**

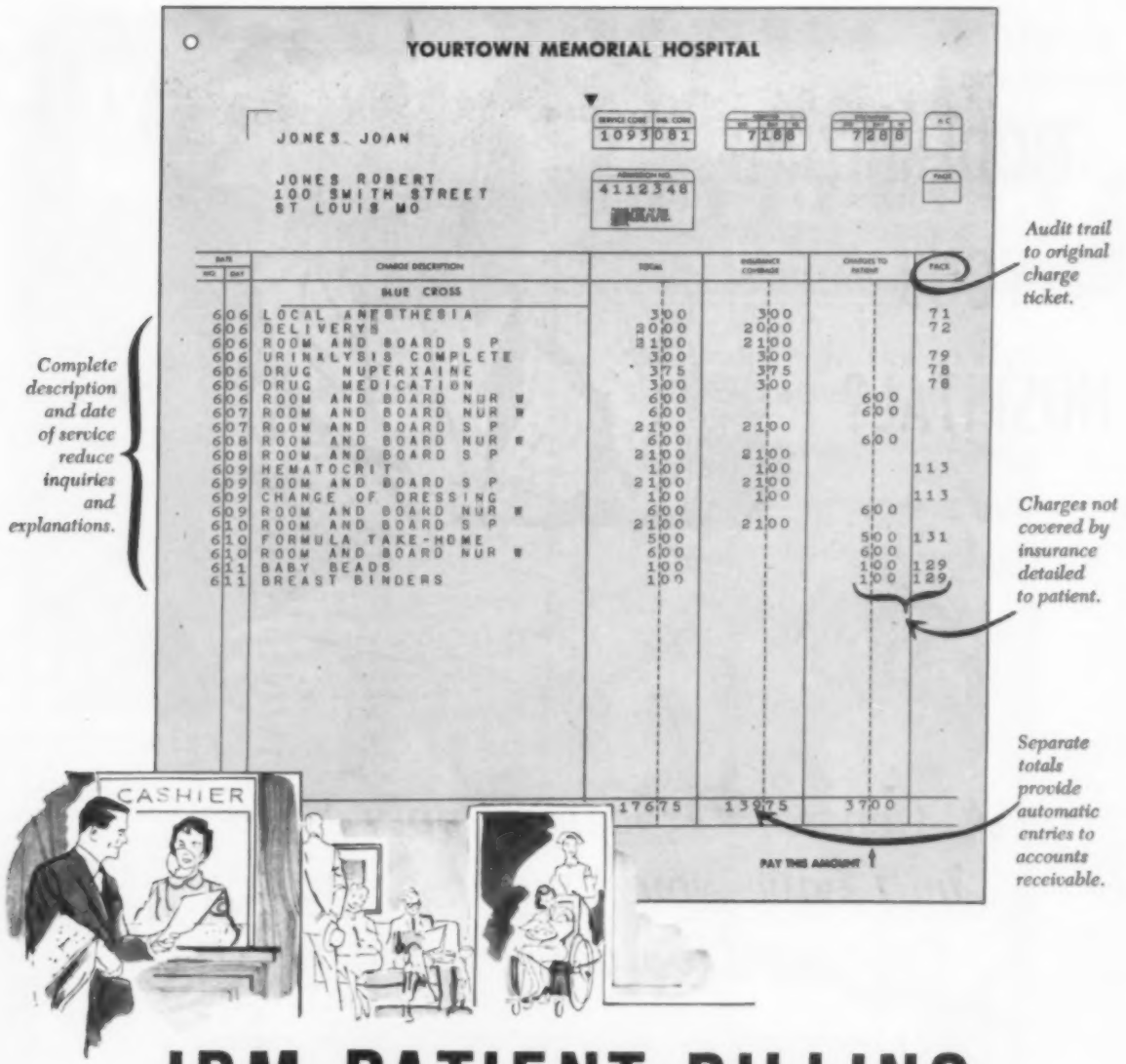
For more details circle #419 on mailing card.

Instant Nonfat Dry Milk Now in Institutional Size

An institutional size which will make five gallons of nonfat milk is available in new Pet Instant Nonfat Dry Milk. The new product is the result of intensive development work and is high in protein with less than one per cent fat. The milk crystals of new Pet Instant are popped so that they dissolve the instant they touch water. The product has all of the B vitamins, calcium and phosphorus of fresh milk with a refreshing flavor. The new package is constructed of aluminum foil, polyethylene and paper and carries instructions for mixing one gallon and one quart. **Pet Milk Co., Arcade Bldg., St. Louis 1, Mo.**

For more details circle #420 on mailing card.

(Continued on page 274)



IBM PATIENT BILLING

includes all charges on final bill

Detailed, up-to-the-minute bills ready as your patients leave—this is only one of the many ways IBM in-patient billing systems help you serve patients better. And items are listed so legibly and in such detail that verbal explanations are reduced to a minimum.

OTHER BENEFITS:

- **Automatic distribution of third-party charges.**
- **Accurate, detailed revenue breakdowns and up-to-the-minute expense reports.**
- **Automatic accounts-receivable control.**
- **Swift and easy preparation of aged trial balance.**

Find out how IBM can modernize your accounting operation. Get the complete facts from: HOSPITAL DEPARTMENT A58-b, International Business Machines Corporation, 590 Madison Avenue, N.Y. 22, N.Y.

IBM DATA PROCESSING

For additional information, use postcard on page 279.

For additional information, use postcard on page 279.

Pharmaceuticals

Gradumet

Gradumet Tral and Gradumet Tral with Phenobarbital are long-acting anticholinergics in oral dosage form. The Gradumet is tablet shaped, consisting of physiologically inert plastic with hundreds of interstitial passages impregnated with the drug. It releases the medication at a gradual, metered rate over an eight to 12-hour period. The process is entirely physical and is not affected by chemical digestion. The active drug, Tral, provides prompt relief of hyperacidity and hypermotility in peptic ulcer patients and is useful in management of gastro-intestinal disorders and certain spastic conditions of the intestinal tract. Gradumet Tral, 50 mg. (yellow) and Gradumet Tral, 50 mg., with Phenobarbital, 30 mg (blue) come in bottles of 50 and 500. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #421 on mailing card.

'Delvex'

'Delvex' (Dithiazanine Iodide, Lilly), broad-spectrum anthelmintic, eliminates four intestinal parasites: whipworm, intestinal threadworm, large roundworm and pinworm. It is also found to be partly effective against hookworm, dwarf tapeworm and the beef tapeworm. 'Delvex' is a blue polymethine dye and a special coating on the tablet permits the medicament to pass through the stomach and into the upper bowel before it is released. 'Delvex' is supplied in three tablet sizes—50 mg. (for small children), 100 mg. and 200 mg. The violet-colored tablets come in bottles of 50. The 100 mg. and 200 mg. sizes are also provided in packages of 1,000. **Eli Lilly & Co., 740 S. Alabama St., Indianapolis 6, Ind.**

For more details circle #422 on mailing card.

Kantrex

Kanamycin sulfate is a bactericidal antibiotic for control of stubborn infections caused by a wide variety of pathogenic organisms, both Gram positive and Gram negative. It is especially valuable in the treatment of infections caused by staphylococci resistant to other antibiotics and in infections of the urinary and respiratory tract. The drug is also recommended for presurgical intestinal antisepsis since it is poorly absorbed from the gut when given orally. It is available in vials for intramuscular administration and capsules for oral administration. **Bristol Laboratories, P. O. Box 657, Syracuse 1, N. Y.**

For more details circle #423 on mailing card.

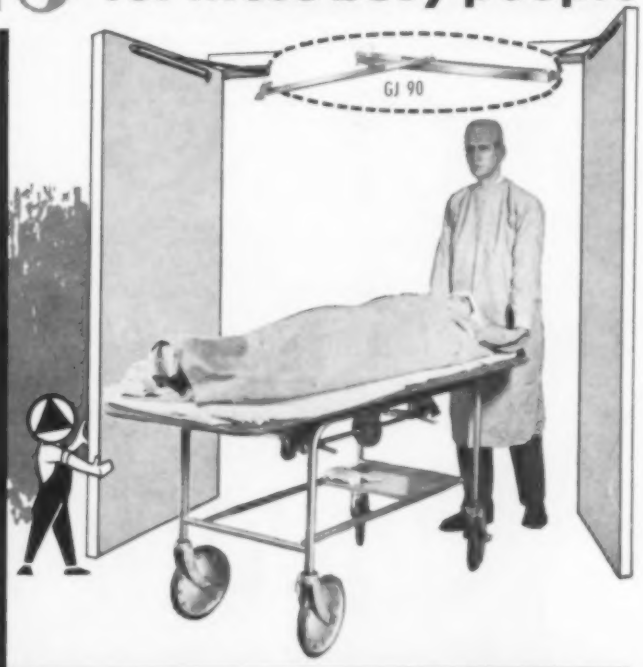
Trilafon Syrup

Trilafon Syrup is a tranquilizer and drug agent for the prevention and control of nausea and vomiting. It is formulated for patients who are unable to swallow tablets or who dislike swallowing them and is particularly effective for children and elderly patients to control conditions of mental agitation. In pediatric medicine, it is particularly valuable in controlling the overactive, emotionally or mentally disturbed child. Trilafon Syrup is also recommended in the management of assaultive, antisocial behavior, chronic restlessness and neurotic defense mechanisms. **Schering Corp., Bloomfield, N.J.**

For more details circle #424 on mailing card.

(Continued on page 276)

let GJ HOLD DOORS for these busy people



a variety of silent, shock absorbing door holders for every hospital door

. . . doors leading to patient, emergency, operating, utility, x-ray, supply rooms and diet kitchens—every door through which the busy staff must pass.

GJ devices go into hold-open silently . . . absorb the shock of a hard opening push. They hold the door securely and yet the door can be released easily with a firm push or pull.

Let us send you this brochure of GJ hardware for hospitals—just write

Be sure it's GJ • the trouble-free hardware maintenance people prefer

GLYNN • JOHNSON CORPORATION
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For additional information, use postcard on page 279.

Literature and Services

• New ideas in lighting fixtures for all types of institutions are presented in the new **"LL" Catalog** released by Meierjohan-Wengler, 1102 W. Ninth St., Cincinnati 3, Ohio. It carries nearly 200 illustrations of **Contemporary and Traditional Lighting Fixtures,** with descriptive information on each.

For more details circle #425 on mailing card.

• The complete line of **Cole Office Equipment** is presented in a newly revised 72-page catalog issued by Cole Steel Equipment Co., Inc., 145 Madison Ave., New York 17. Printed in black and white and color, the catalog carries descriptive details with illustrations on furniture, filing equipment, folding chairs, refinish enamel, cabinets, counters, lamps, lockers and other office equipment.

For more details circle #426 on mailing card.

• The Lupton curtain wall system, developed in cooperation with leading architects, is the subject of the 16-page **Catalog SCW-580** issued by Michael Flynn Mfg. Co., 700 E. Godfrey St., Philadelphia 24, Pa. The catalog gives general and specific design data for the two main types of Lupton curtain walls which are designed specifically to form complete exterior walls for single or multi-story buildings of any type. Construction details with scale drawings of parts and typical elevations showing patterns are also included.

For more details circle #427 on mailing card.

• **Vogt Bent Tube Boilers, Class VF and VS,** are described in **Bulletin VF-VS2** available from Henry Vogt Machine Co., Box 1918, Louisville 10, Ky. Charts and photographs illustrate details of actual installations in hospitals and other institutions.

For more details circle #428 on mailing card.

• A four-page folder, SPG-4286, **"Flo-Chart for Hospital Record Microfilm System,"** carries a description of a new, modern, tried and proved hospital case history filing technic developed by Remington Rand, 315 Fourth Ave., New York 10.

For more details circle #429 on mailing card.

• A comprehensive report on the design flexibility afforded by the use of **Acousti-Lux Panels** is presented in a 12-page brochure published by The Celotex Corp., 120 S. La Salle St., Chicago 3.

For more details circle #430 on mailing card.

• A series of color, sound filmstrips on **various phases of floor care** and the materials used are available from Multi-Clean Products, Inc., Ford Parkway, St. Paul 16, Minn., or from its local distributors.

For more details circle #431 on mailing card.

• How Tubegauz can be applied to any part of the body by using cage-type or splint applicators is described and illustrated in a manual, **"New Technics of Bandaging With Tubegauz,"** available from Dr. Scholl's, 213 W. Schiller St., Chicago 10. Information is also given on the five sizes of Tubegauz for general bandaging and the two sizes for body bandaging, eight sizes of cage-type applicators and two sizes of splint-type applicators.

For more details circle #432 on mailing card.

• A comprehensive catalog, prepared in file form, is available on the **full line of kitchen equipment** manufactured by United Manufacturers, 30 Windsor Place, Nutley 10, N.J. Included is information on Universal commercial-type dish, glass and silver washers, Sanitary scales, slicers, choppers and saws, Triumph vertical and horizontal mixers, and MJM vegetable peelers.

For more details circle #433 on mailing card.

• The new **Type HP movable wall system** developed by E. F. Hauserman Co., 7516 Grant Ave., Cleveland 5, Ohio, is the subject of a 12-page brochure recently released. Key features, complete architectural specifications and detailed sectional drawings of the wall system are presented in the fully-illustrated booklet.

For more details circle #434 on mailing card.

• Young's Wheeled Equipment for institutional use is listed and described in **Catalog No. 57** released by The Paul O. Young Co., Line Lexington, Pa. The 24-page booklet illustrates and describes carts, trucks, bags, drum stands and other housekeeping and maintenance equipment for hospitals and other institutions. Illustrations show equipment in use and a price list is included.

For more details circle #435 on mailing card.

(Continued on page 278)

3 CHEERS

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For additional information, use postcard on page 279.

• **"This Is Haemo-Sol"** is the title of an 8-page report published by Meinecke & Co., Inc., 225 Varick St., New York 14. The comprehensive report presents technical data on Haemo-Sol, the cleanser specifically formulated to produce chemically clean instruments and glassware.
For more details circle #436 on mailing card.

• Twelve different paint stripping compounds and four methods commonly used to remove paint are discussed in a new booklet, **"How to Strip Paint,"** published by Oakite Products, Inc., 19 Rector St., New York 6.
For more details circle #437 on mailing card.

• **Coleman Spectrophotometers** are the subject of two bulletins recently released by Coleman Instruments, Inc., 318 W. Madison St., Maywood, Ill. **Bulletin B-241** discusses the Coleman Universal Spectrophotometer while **Bulletin B-240-A** features Junior Spectrophotometers.
For more details circle #438 on mailing card.

• Moderate speed **traction-drive, counterweighted electric dumbwaiters** manufactured by Energy Elevator Co., 212 New St., Philadelphia 6, Pa., are described and illustrated in a new 4-page brochure.
For more details circle #439 on mailing card.

• **"Clinical Use of Gauztex, The Sterile Self-Adhering Bandage"** is the subject of a 16-page booklet on bandaging procedures. Available from General Bandages, Inc., 8300 Lehigh Ave., Morton Grove, Ill., the booklet is suitable as a reference work on bandaging and is illustrated with helpful diagrams.
For more details circle #440 on mailing card.

• **"Guide for Purchasing Complex and Unusual Alloy Sheet and Light Plate Fabrication"** is the title of a 30-page illustrated booklet describing the types of products and equipment produced by S. Blickman, Inc., Weehawken, N.J. Detailed descriptions with photographs and sketches of products and fabricating technics make this a permanent handy reference manual.
For more details circle #441 on mailing card.

• **"Curtis Aluminettes,"** the attractive partitions combining extruded aluminum with plastic, metal or fabric surfaces to make solid or partial walls in a variety of textures and colors, are the subject of an 8-page bulletin released by Curtis Office Partition Co., Inc., 103 Union St., Brooklyn 31, N.Y. Color illustrations of the design possibilities of the partitions supplement the factual information presented.
For more details circle #442 on mailing card.

Book Announcements

Harrow and Mazur, "Textbook of Biochemistry," 7th ed., 557 pp., $7.50. Howe, "Nutrition for Practical Nurses," 2nd ed., 219 pp., $2.75. Noller, "Textbook of Organic Chemstry," 2nd ed, 654 pp., $7. **W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa.**
For more details circle #443 on mailing card.

Suppliers' News

Armstrong Cork Co., Lancaster, Pa., announces availability of its **Bureau of Interior Decoration** to hospitals and pharmacies planning remodeling projects. The program offers individual Custom Design Service at no cost, including a floor plan and color scheme, according to the release which states that the new service will be made available through Armstrong wholesale distributors.

C. R. Bard, Inc., Summit, N.J., announces that beginning August 12 the **"Fleet" Enema** will be available to hospitals and surgical distributors under the brand name **"Bardic"** through an arrangement made with the **C. B. Fleet Co.** Included are three ready-to-use enemas in disposable plastic squeeze bottles for hospital use: a phospho-soda formula adult unit, the new pediatric size phospho-soda, and a rention-type mineral oil unit.

Formica Corporation, 4614 Spring Grove Ave., Cincinnati 32, Ohio, a subsidiary of **American Cyanamid Company,** announces the formation of a **Decorative Arts Department** to provide original paintings, murals and patterns permanently preserved in tough, washable laminated plastics. Several processes have been developed for Formica Decorative Arts and are available to institutions desiring customized art work that will last indefinitely with minimum upkeep.

Plastics Mfg. Co., 2700 S. Westmoreland, Dallas 33, Tex., manufacturer of **Dallas Ware** melamine plastic dishes since 1945, announces completion of its modern air-conditioned plant in the Santa Fe Industrial District of Dallas. The company also manufactures (**Regal Ware** for institutions, Konite plastic tumblers, goblets and sherbets, and Texan Tray, a laminated Fiberglas and polyester resin serving tray.

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TO REQUEST PRODUCT INFORMATION FOLD THIS FLAP OUT AND USE THESE CARDS

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The two cards below are detachable and are addressed to us. With this flap folded out you can turn through the magazine for the items on which you want further information.

When, in either an advertisement or "What's New" you locate the product, turn to the index to advertisements on the following page or to the index of "What's New" items (left) where you will find the key number for the item. Items advertised are listed alphabetically by manufacturer. "What's New" items are in Key Number order. Circle the corresponding key number on the card below for each item in which you are interested. The second card is for the use of someone else who may also want product data.

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